

SAFETY FOR SURVIVORS: CARE AND TREATMENT FOR MILITARY SEXUAL TRAUMA

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON VETERANS' AFFAIRS U.S. HOUSE OF REPRESENTATIVES ONE HUNDRED THIRTEENTH CONGRESS FIRST SESSION

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SAFETY FOR SURVIVORS: CARE AND TREATMENT FOR MILITARY SEXUAL TRAUMA

Friday, July 19, 2013

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 9:57 a.m., in Room 334, Cannon House Office Building, Hon. Dan Benishek [Chairman of the Subcommittee] presiding.

Present: Representatives Benishek, Roe, Denham, Wenstrup, Walorski, Brownley, Ruiz, and Kuster.

Also present: Representatives Kirkpatrick, O'Rourke, and Speier.

OPENING STATEMENT OF CHAIRMAN DAN BENISHEK

Mr. BENISHEK. Good morning, everyone. The Subcommittee will come to order. Before we begin, I would like to ask unanimous consent for my friends and fellow Committee Members, Gus Bilirakis, Ann Kirkpatrick, Dina Titus, Tim Walz, Beto O'Rourke, and Doug Lamborn, and our colleague Jackie Speier, to sit at the dais and participate in today's proceedings. Without objection, so ordered.

With that, I welcome you to today's hearing, "Safety for Survivors: Care and Treatment for Military Sexual Trauma." I am grateful to you all for being here today.

When the men and women of our armed forces sign up to defend our freedom, they willingly accept the threat of danger from our enemies. But what they should never have to accept is the threat of sexual assault from their fellow servicemembers. Perpetrators of military sexual trauma should be aggressively pursued, prosecuted, and punished. I, along with many of my colleagues here, are working to advance legislation to reform and improve the military justice system. Just as important as that effort, however, is the one we turn to today: listening to, caring for, and supporting the healing of those who have suffered this terrible crime.

According to the DoD, there were roughly 38 incidents of sexual assault among male servicemembers and 33 incidents of sexual assault among female servicemembers per day last fiscal year. Let me repeat, last fiscal year that were roughly 71 incidents of sexual assault every single day among those who wear our uniform. To say this is unacceptable does not adequately describe the terrible reality of military sexual assault and the lasting effects it can have on the lives of those who experience it. A servicemember who is a victim of sexual assault is often hesitant to disclose their experience or seek the supportive services that they need and deserve.

While this is troubling to me, it is even more troubling to listen to the personal stories of those who have taken the brave step to

come forward and find that those departments tasked with caring for them, the Department of Veterans Affairs and the Department of Defense are unresponsive, uncoordinated, and unable to meet their obligations to these survivors.

In January of this year, the Government Accountability Office issued a report which found, among other things, that DoD sexual assault coordinators, who are allegedly the single point of contact for sexual assault survivors, and who are tasked with managing their medical needs within the Department of Defense are, quote, “not always aware of the health care services available to sexual assault victims at their respective locations.” The GAO also found that military health care providers did not have a consistent understanding of their responsibilities to care for sexual assault victims.

Further, a VA Inspector General report issued last December found that, among other things, VA’s military sexual trauma coordinators, who are the single point of contact for veterans who have experienced military sexual trauma within VA facilities, report as little as 2 hours a week to conduct outreach to and monitoring of those veterans who have screened positive for military sexual trauma.

What confidence can assault survivors have when, at their lowest moment, DoD and VA fail to understand their own responsibilities to provide care, fail to provide the health care options that are available, and fail to empower their most direct point of contact with the knowledge, authority, and the tools to be effective, not just present?

The answer to that question lies in the voices of our veterans themselves. In preparing for this hearing, we spoke with many veteran survivors of military sexual trauma and those who work closely with them. Their frustrations and concerns were legion. I am honored to have four such veterans with us this morning. These veterans represent four branches of the services, the Army, the Air Force, the Navy, and the Marine Corps, and eras of service from the Vietnam war to the conflicts in Iraq and Afghanistan.

These brave men and women have endured firsthand the heart-break and pain associated with military sexual trauma. They know better than anyone how very long and difficult the journey to healing can be. Each of them has braved public scrutiny and the reliving of very painful memories to be here today, to share with us their experiences, in the hopes that we might do better for those that come after them.

Your contribution here today will bring out of the shadows and into the light a much-needed call for change. I thank each of you for your honorable service to our Nation and to your fellow veterans, a service which began in uniform years ago and continues here today.

I will now yield to our Ranking Member, Julia Brownley, for any opening statement she may have.

OPENING STATEMENT OF HON. JULIA BROWNLEY

Ms. BROWNLEY. Thank you, Mr. Chair.

And good morning to everyone. I would like to thank all of you for attending today’s hearing focused on examining the care and treatment available to survivors of military sexual trauma. The

Subcommittee will also be looking at the coordination of care and services offered to the victims of MST through the Department of Veterans Affairs and the Department of Defense.

Many MST victims who have suffered through an ordeal such as sexual assault, oftentimes, are reluctant to discuss their situation and seek help. Those that finally gather the courage to speak up find that their story is often dismissed or treated indifferently, unjustly, becoming the victim again.

As many of you know, the Pentagon reported earlier this year that an estimated 26,000 cases of unwanted sexual contact occurred in 2012, up from 19,000 in 2011. With only 13.5 percent of incidents reported, it is clear that we must do a better job in both preventing and treating MST. These servicemembers and veterans often continue to experience debilitating physical and mental symptoms from MST which can follow them through their lives.

Focusing on prevention, however, is only part of the solution. It is critical that we do everything that is necessary to do, to make it easier for victims of MST to access needed benefits and services and receive treatment. Compassion and care are a significant part of healing those that have been sexually assaulted.

I applaud the legislative efforts of our colleagues who have introduced legislation, H.R. 1593, the Sexual Assault Training Oversight and Prevention Act, and H.R. 671, the Ruth Moore Act. These bills seek to ensure stronger protections are in place, so that the safety and well-being of our men and women in uniform is assured. We must begin to take these important steps to end sexual assault. As a proud cosponsor of both bills, I believe we are headed in the right direction, but we still need to do more.

I was saddened to read the testimonies of our first panel. The pain and suffering was evident in the personal stories written. I know that this is hard for all of you, and I commend all of you on your bravery to speak up and be here today. We need to hear firsthand the experiences of veterans who have found the system unfriendly and intimidating so that we can make it better. I look forward to hearing from our witnesses today.

Again, I thank you for being here. This is a very important issue for us to tackle here in Congress.

And I thank you, Mr. Chairman, and I now yield back.

[THE PREPARED STATEMENT OF HON. BROWNLEY APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Ms. Brownley.

I would now like to formally welcome our first panel to the witness table. Will the panelists please come forward?

Joining us today is Victoria Sanders from Novato, California. Ms. Sanders is a veteran of the United States Army and a former registered nurse.

Thank you very much for being here and for your service.

I will now yield to my friend and colleague from Indiana, Jackie Walorski, who will introduce our next veteran witness, Lisa Wilken.

OPENING STATEMENT OF HON. JACKIE WALORSKI

Mrs. WALORSKI. Thank you, Mr. Chairman. Thank you for yielding and for your commitment and the commitment we share with this Committee in addressing this critical issue for the survivors of military sexual trauma. And I want to thank every Member up here for voting yes on the whistleblower protection bill that we passed through the House with a huge bipartisan group, and many of the cosponsors are sitting here today.

It is my honor to introduce Lisa Wilken from Westfield, Indiana, a United States Air Force veteran who was sexual assaulted and consequentially, 100 percent disabled as a result of the trauma endured from her horrific attack. Lisa is more than just a wonderful wife and a dedicated mother. She is a survivor. She is a survivor who has made it a mission to bring other victims out of the isolation and the shadows that they suffer through. She is also a veteran, and she has the right to receive access to meaningful treatments.

Lisa, Victoria, Brian, and Tara, thank you for having the courage to testify before this Committee today. Thank you for your tireless efforts to hold the VA accountable for treating victims of military sexual trauma.

Mr. Chairman, I yield back.

Mr. BENISHEK. Thank you, Jackie.

And thank you, Ms. Wilken, for being here today and for your service.

Our next veteran witness is Brian Lewis from Baltimore, Maryland. Mr. Lewis is a veteran of the United States Navy and a recent graduate of Stevenson University.

Mr. Lewis, thank you very much for being here and thank you for your service.

We are also joined by Tara Johnson. Ms. Johnson was born and raised in New Jersey, and currently resides in Lake Mills, Wisconsin. She is a veteran of the United States Marine Corps and currently serves her fellow veterans as an Army wounded warrior advocate.

Ms. Johnson, thank you very much for being here, and thank you for your service.

Ms. Sanders, would you please proceed with your testimony? The way it works is, you have 5 minutes to testify, and we would like to try to stick to that, to be polite with our time. Thank you.

STATEMENTS OF VICTORIA SANDERS, VETERAN; LISA WILKEN, VETERAN; BRIAN LEWIS, VETERAN; AND TARA JOHNSON, VETERAN

STATEMENT OF VICTORIA SANDERS

Ms. SANDERS. Thank you. Thank you, Mr. Chairman, Representatives and panel. I want to thank you for this chance to speak before this Committee. It is like a birthday gift from Congress because yesterday was my 58th birthday.

Thirty-eight years ago, on my 20th birthday, I arrived at my only active duty station in Fort Carson, Colorado. One month later, I was raped. In the middle of the legal battle around the rape, I was thrown into a custody battle. After basic training, I separated from

my husband and had one child. No 20-year old private in the military should ever have to fight these battles alone, but that is what I did. I was diagnosed with PTSD in 2004. It has been a long, hard road, and I am hoping my testimony today will help me come full circle.

My rapist confessed to enough of his crimes that he was reduced in rank, lost pay, and was confined to barracks. This is an example of chain of command harassment because the barracks he was confined to was the one where I worked and he still worked in the office next door.

When you report a rape you become public enemy number one. No one will talk to you. And if they do, it is to tell you, you got what you deserved. You are called names, you internalize what happened, and it feels like it is your fault. Even if your rapist is punished, harassment is limitless. It followed me through three transfers in 9 months.

I had an out because my custody battle made me a single mother. At the time single parents were discharged quickly. They let me go. But I began the slow decline in mental health known as post-traumatic stress disorder. When you are raped it takes a piece of your soul. Being raped by a fellow servicemember is a double betrayal, but not being backed up about your commanders is the hardest betrayal of all.

Because the innocent are treated as criminals, we have lost good people on each step of this journey. Today, I want to mention two: Carri Goodwin and Sophie Champoux. They did not live long enough after being raped to become veterans.

My experience with the VA mental health was at first supportive, caring, trained professionals. We had a great PTSD clinic in San Jose. I watched it go from a thriving program for both men and women to a ghost town. I was one of a group of five women who were not eligible to go for inpatient treatment for various reasons. Dr. Alana Pavar and her student Mylea Charvat started a process group for the five of us. This is usually only done in an inpatient setting. Three weeks into the program, she was told by her boss that she could not continue this therapy with us. She did, however, finish out the 17-week program. She was not going to leave us. Our world was crushed.

The student who worked with her watched us, and as she watched she decided to change her focus to trauma, and specifically military sexual trauma. She went to work at the VA after she completed her studies. Mylea worked there until she was offered a job at Stanford that allowed her the time to spend with patients, to be available, and consult for a program in Santa Barbara. It does intensive therapy using EMDR processing therapy and many things not available at most VA facilities.

This shows me we patients are powerful, but only when we are allowed to have meaningful therapy, not just the same basic skills. How many times can a person take the same information in the same form from a student reading from a book. That is not therapy.

Since I have moved my care to the San Francisco VA, I have only seen two actual full-fledged doctors. The rest were interns, residents, doctoral candidates, doctoral fellows that were not licensed

and trained in specific trauma therapy. I was retraumatized on many occasions. All of that is outlined in my written testimony.

I believe Paula J. Caplan was right when she said being devastated by an assault is not a mental illness. Furthermore, it has been well documented that psychiatric diagnosis is not scientifically grounded, does not improve outcome—that is, does not reduce human suffering—and carries tremendous risks of many kinds. Assault survivors should be offered services without the requirement they be given psychiatric labels. These can be arbitrary and very subjective.

Further complicating matters is there is no universally accepted ideal treatment for PTSD. Having a diagnosis of PTSD does nothing without comprehensive care.

As for the future of this problem from the military to the VA, what I see is more of the same. Most of the chiefs of staffs were cadets when I was raped in 1975. This year at West Point they had to disband the rugby team for inappropriate behavior. The number of failures this year alone is too long to list. This climate must change. Every day, 71 more people are assaulted and 22 veterans commit suicide and we don't know how many of those are because of assaults and rapes.

[THE PREPARED STATEMENT OF VICTORIA SANDERS APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Ms. Sanders. I truly appreciate your words.

Ms. Wilken, please go ahead.

STATEMENT OF LISA WILKEN

Ms. WILKEN. Thank you. I am a United States Air Force veteran. I was medically separated after a sexual assault, and I am currently rated 100 percent service-connected by the Department of Veterans Affairs. I am a wife and a mother, and more importantly, I am a military sexual trauma veteran. In my opinion, that is the DoD and the VA's way of categorizing us as we are rape survivors of friendly fire. And I use those terms not to make a joke of it, but to bring it home that we were assaulted by someone who wore the uniform as we wore and not all people wear the uniform as honorably as you do.

Thank you for giving me the opportunity to speak today. I have struggled for many years to be proud of my service because of the experience that I had in the military, but speaking out about this topic makes it so that if another veteran doesn't have to suffer and struggle with the things that I have struggled with, it is important for me to do so. And not a day goes by that I don't deal with something that is a result of the sexual assault.

Why is PTSD from assault so long lasting? I believe the reason for that is that it is not properly treated or dealt with at the time. The treatment that we receive when we report an assault in the military, it is as if we are the perpetrator. We are the ones who are put under the microscope. And that is something that needs to stop. It is almost as if your chain of command sets out to do some type of emotional blackmail on you, or emotional trauma, and that

is something that a rape survivor can't handle at that time. You are in a closed society.

Most people don't realize how much the VA treatment facilities mirror our military treatment facilities. And so that is one of the big hurdles that the VA must start with, is recognizing that there are a lot of men and women that will not come to the VA for treatment because of the experience that they had in the military or because at the time there wasn't the whistleblower protection and they didn't report it. But now that they are older and having problems, they won't come to the VA because of their experience in the military.

You are going to hear me speak a little bit about outside treatment facilities. We need the ability to go outside of the VA, if services are not available for us at that VA medical center, so that we don't have to suffer in silence. We need groups at our VA medical centers for support, and we need groups outside of VA facilities.

Most people don't realize that sexual assault is not something that you can be treated for. It is not like a broken arm where your arm is in a cast for 6 weeks and then you are fine. Military sexual assault or sexual assault in general, is something that changes a person from that point forward. It takes the opportunity of what you could have become and changes it to what it makes you.

Why is it so important that we speak out about this topic? The reason that it is so important that we speak out about this topic is so that other men and women who are currently wearing the uniform understand that they are not alone and that there are people out there that will stand up for them.

One of the things that is important to realize is in our treatment we need better resources. And those resources can be outside of the VA in our local communities. Right now, at our Indianapolis VA medical center, the wait to get into see someone to treat you for military sexual trauma is almost 2 years. If we could utilize our local health care providers and mental health providers, I know the men and women in Indiana would utilize that. Unfortunately, getting approval from the VA to go outside is a difficult process, and it is not something that is done easily.

We have MST coordinators at all of our VA facilities. Unfortunately, they are generally just one person and they have other assigned duties. We need military sexual trauma coordinators at all of our VA facilities that have a staff, that they are able to do things more than just push the paperwork for those veterans; that they are able to interact with that veteran and make sure that the veteran is receiving the care that they need, and if they are not, have the ability to stand up for that veteran. Because those are the things that we didn't get while we wore the uniform. And being able to have those services available to us now can change people's lives.

Thank you for your time.

[THE PREPARED STATEMENT OF LISA WILKEN APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much for your testimony.

Mr. Lewis, please proceed with your testimony.

STATEMENT OF BRIAN LEWIS

Mr. LEWIS. Chairman Benishek, Ranking Member Brownley, distinguished Members of the Subcommittee, and Members of Congress sitting with the Subcommittee, it is a privilege and honor to be testifying before you here today. I would like to thank my partner Andrew Beauchene, who could not be here today. Our significant others allow us to do so much, and they receive so little credit for the time, effort, and energy that they put into us as survivors. And I want to acknowledge that before I start.

I would also like to thank the Subcommittee for treating the issue of military sexual trauma in a gender-inclusive way. As the Chairman pointed out in his opening statement, about 14,000 of the 26,000 sexual assaults on active duty are male victims. This gender-neutral conduct places the Subcommittee further ahead than the White House and very much ahead of the Veterans Health Administration. Indeed, it has been my experience that the Veterans Health Administration discriminates against male survivors of military sexual trauma solely because of their gender. This is a practice that needs to be brought to light and stopped by the Subcommittee.

Currently, the Veterans Health Administration operates about 24 residential treatment programs for post-traumatic stress disorder. Only about 12 were designed specifically for the treatment of military sexual trauma. Of those 12, only one accepts male patients. That facility, the Center for Sexual Trauma Services at VA Medical Center Bay Pines is coeducational. Put simply, male survivors have no single-gender residential treatment program designed specifically for military sexual trauma. I know, I tried. There was nothing available for me in a single-gender capacity.

This made it very difficult to process the issues when I was at VA Bay Pines. I join the American Legion in saying that the coeducational model of residential treatment programs needs to be overhauled, and quickly.

In the outpatient environment, care for male survivors of military sexual trauma can be spotty at best. While there are counselors available for us, receiving care such as peer support groups and being allowed to speak about military sexual trauma in mixed gender and/or mixed trauma groups, by which I mean combat PTSD and military sexual trauma mixed together, can be very difficult for any veteran, male or female. This needs to stop. Male survivors are the equals of female survivors and need to be treated as such by the Veterans Health Administration.

I have placed more substantive data in my written testimony about my personal treatment at VA Bay Pines and at the Baltimore VA Medical Center, and I will leave that in there. The next topic I would like to touch upon is the overall supervision of military sexual trauma.

The overall supervision of military sexual trauma programs within the Veterans Health Administration has been vested in the Director of Women's Mental Health, Family Services, and Military Sexual Trauma. This oversight protocol denigrates the experience of male survivors and reinforces the concept that the Veterans Health Administration sees military sexual trauma as a, quote/unquote, "women's issue." That is not the case. Male survivors have

just as much right to seek and be treated at the VA as any other survivor.

Another harmful practice is personality disorders. As this Subcommittee is well aware, personality disorders have been used, along with adjustment disorders, bipolar disorders, and many other forms of errant and weaponized psychiatric diagnoses to push survivors of military sexual trauma out of the military. And it has far-reaching consequences. For example, survivors attending the Topeka, Kansas, facility are asked to defend their discharge and explain it on the application to enter Topeka, Kansas' program. A survivor who has been pushed out with one of these weaponized diagnoses does not want to do that.

So I strongly urge the Subcommittee Members to support H.R. 975, the Servicemember Mental Health Review Act, offered by representative Tim Walz. This legislation would give veterans like myself who have been misdiagnosed with personality disorders to apply for potential military retirement and shift some of these costs back to where they belong.

In conclusion, the Veterans Health Administration fundamentally fails male survivors of military sexual trauma every single day. They have proven their inability to adequately care for us. That is why me and several other survivors have founded Men Recovering from Military Sexual Trauma, an organization designed to help and advocate for male survivors. We respectfully request Congress to legislate equality in practice for male survivors of military sexual trauma.

Thank you, Mr. Chairman.

[THE PREPARED STATEMENT OF BRIAN LEWIS APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Lewis, for your testimony. I truly appreciate your efforts here.

Ms. Johnson, would you please go ahead?

STATEMENT OF TARA JOHNSON

Mr. JOHNSON. Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee, thank you for the opportunity to speak today. I proudly served in the Marine Corps for 10 years and achieved the rank of Major. I am now 40 years old, and this is the first time I have ever disclosed my experiences regarding MST and the care I received or did not receive from DoD and the VA.

I joined the Marine Corps because I wanted to serve my country. My first incident of MST occurred when I was an officer candidate and I was sexually assaulted by a senior officer. Throughout my career in the Marine Corps, I endured several more incidents of MST. I did not disclose these experiences, as I had seen the unfair treatment of those who had reported incidents to their command.

Despite these experiences, I excelled in the Marine Corps and lived the motto so familiar to Marines as suck it up and press on. I spent almost 8 years in active duty. I returned as a reservist on active duty in 2009. Again, I experienced an incident of MST. I began to suffer from depression, anxiety, and panic attacks.

During this period, I did find the courage to approach my command regarding these incidents. My statements were simply dismissed, and I endured even more harassment and abuse. I sought and received medical treatment for panic attacks, medication, but I was never asked about MST by medical personnel. I was put on medication to relieve depression and anxiety. It got so bad I requested early release from these active duty orders because the situation was just so difficult I felt I could not endure it any longer.

This decision to leave active duty early placed me, as well as my children, in an extreme fragile financial state for a very significant period of time. The complete pride I have felt as a Marine in the past is now riddled with shame, self-doubt, and distrust. In October 2010, I sought treatment from the Madison, Wisconsin VA. I received extremely limited treatment for the depression, anxiety, and panic, and I was mainly prescribed medications. While it was evident through screenings, I had severe symptoms of PTSD, I was never asked by a provider if I had experienced MST. So basically, I came in, I had undergone these screenings for PTSD, but yet, I wasn't a combat veteran, but yet no one looked at these symptoms and these screenings and said, well, what is actually causing this? What is happening here?

For the first time in my life I contemplated suicide, but I knew I needed to continue to cope for the sake of my children. While the psychiatrist I saw was helpful, it was extremely difficult for me to receive consistent treatment at this time as I was not yet service-connected, and I received little to no medication monitoring. And I sincerely feel that the medication caused even more depression and more anxiety and was the reason I had contemplated suicide.

In December 2010, I had my comp and pen exam for mental health. I entered this exam with the hope that the provider would address MST and I would finally be able to receive help. The doctor spent 20 minutes with me. He was extremely abrupt and impersonal and did not once ask me about anything related to MST. I was not given the opportunity to disclose my experiences. He ended our appointment very quickly, stating he was sure I would be fine, and my hope deflated.

The next few months, as I waited for service-connection, I was informed that because of my income the prior year, even though I was currently unemployed, I would have to pay for any care that I received from the VA during this time. I was not yet financially stable and could not afford extra costs as a single mother of two boys. I then contacted the transition patient advocate at Madison and disclosed my MST experience. He immediately contacted the regional office and attempt to have MST added to my claim. I was directed by the regional office to prepare and submit a statement that described the details of my assault and other incidents. Though extremely difficult, I completed and submitted this statement. I was hopeful the information I provided would allow me to receive another examination where I could address my experiences of MST.

Despite fulfilling their requests, I was not granted another exam. I continued to struggle my symptoms and memories as well as severe side effects from medication. Because MST was not addressed

in any of my exams, I was told I was not able to utilize the local vet center.

Several months later, I did receive my service-connection and was able to meet with a provider. During intake for the PTSD program, the VA provider again did not ask about MST, but I decided I needed to disclose my experiences. I was extremely detailed and candid. This provider informed me that I did appear to have severe PTSD and would really benefit from treatment. My sense of relief quickly disappeared as she informed me the wait list for PTSD treatment was at least 4 months long.

When I did get the opportunity to begin treatment, my provider was only at the VA twice a week. I was a working single parent and it was extremely difficult to schedule consistent appointments. There were instances I would take time off work and arrive at an appointment only to be told it was canceled. I was also made aware that even though the hospital had canceled these appointments, my patient record reflected I had no showed or canceled myself. This was simply not the truth. I grew more distrustful and frustrated.

I was then informed I was non-compliant, because I felt I couldn't participate in a therapy called prolonged exposure therapy for fear that it would increase my symptoms, panic attacks, and affect me personally and professionally.

Throughout this period, I also received limited medical care at the VA through the women's health program. No VA nurse or doctor ever asked me if I had experienced MST, though several of my medical conditions have been directly correlated with MST. During this time, I was also employed at the VA in the same program. MST was not addressed. And though there was an MST coordinator at this hospital, I had never had the opportunity to speak with her, and I had never witnessed any collaboration between the women's health program manager and the MST coordinator. I attempted to speak to my program manager several times regarding the need to address the issues of MST with our veterans, but I was unsuccessful.

In 2012, I decided to attempt to engage in treatment at the VA once again. I was assigned a male provider who was new to the VA. During my first appointment, through tears and fear, I again disclosed my experience with MST. The provider looked at me, widened his eyes, sat back in his chair and said, "Well, do you really think you were raped?" I could not bring myself to return to the VA. And it was at this time that I began to utilize my private insurance. I now pay out of pocket for all of my therapy.

Based on my experiences and those of other veterans I have worked with and spoken with, I recommend the VA reconsider their approach to MST screening, acknowledgment, and treatment. The VA needs to become a safe environment where MST is acknowledged. If I had only been asked about my experiences with MST, I would have provided full disclosure. I, like many, was never asked.

Thank you.

[THE PREPARED STATEMENT OF TARA JOHNSON APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much for your testimony.

Unfortunately, they called votes on the House floor. So we will be back in session as soon as they conclude. I truly appreciate all of your testimony, and the bravery that you all have shown to come here and testify about these deeply personal and difficult events.

We will be in recess until I get back.

[Recess.]

Mr. BENISHEK. The Subcommittee is called to order. I am going to yield myself 5 minutes for questions.

Frankly, the testimony that I heard from all of you today is, really, really revealing and tragic, and I know that there is bipartisan support in the Subcommittee to make significant changes in the way DoD and VA treat victims of sexual trauma.

I think maybe the most interesting—and I heard this before from other cases—of the testimony that I heard from you, Ms. Sanders, was the fact—and I think this sort of came out in all of your testimony—that you never get someone at VA, if you ever get into counseling, that is a consistent provider. I know how difficult that is trying to talk to somebody that doesn't know your case.

Can you expand on your testimony there, Ms. Sanders, and make us all aware how difficult it is to get a consistent provider, even once you have gotten a provider, or has it been so bad that you never were able to get anybody consistently?

Ms. SANDERS. When I first entered the system, there was a fantastic clinic, and they treated us very well. They went out of their way to make sure we got the treatment we needed. But it was led by a very dynamic person. That was dismantled, and we were left with scraps. Ended up, I was the only person going to that clinic and was seeing a social worker, and unfortunately she passed away, so I was left with no care.

I moved to north of San Francisco because I had a grandchild and I started care at the San Francisco VA because I can't drive very far, and I have had no real care in 2 years. I asked for a fee basis. I got a fee basis at one point. I took it to our local county. They closed the county office the second day I was there. And it was a facility that treated both civilians and military sexual trauma victims, and people who were coming out of jail and trying to get off of drugs and trying to get their children back.

I have since asked again for a fee basis. I was told, you have got a fee basis for two sessions. I was never told where to take that fee basis. I was never told who to contact. I attempted to say, okay, I have Medicare, can we get some movement on that? I received a phone call. They said, go on the computer and look up caregivers in your—

Mr. BENISHEK. That was all the guidance you got?

Ms. SANDERS. Excuse me?

Mr. BENISHEK. That was all the guidance that you got?

Ms. SANDERS. I have in front of me a fee basis that I was supposed to receive from May. I never got the letter in the mail. I called after 6 weeks because I was told, we don't know how long it will take. And she said, oh, it is already expired. So they sent it to me and it expired July 17th. I still have no one to take it to, no help to find anyone to take it to. I asked if a social worker could sit down with me and make the phone calls if they didn't want to

do it, but I alone cannot just sit down and call every provider in my county to find out who will take the VA's fee basis.

The one person I contacted said it would cost me \$450 for the first session and \$280 for every session after that, and she had to have the money up front, and I had to go get the money from the VA. And then I came here.

So I am hoping that by coming here and telling you guys that a measly two fee basis is not going to get me anywhere. No decent provider is going to say, oh, yes, I will see you twice and then we will wait and see how long it takes for them to get back to us. A real provider wants to give care consistently and comprehensively, and that can't be done with two fee basis at a time.

Mr. BENISHEK. Yeah, of course.

Ms. SANDERS. Does that answer your question?

Mr. BENISHEK. Well, yes, it gives us a feeling of what is going on because it is just so frightening, frankly, the testimony that we have heard here this morning. And I know that there is great bipartisan support to make this better. But, my frustration persists.

I thank you. And I am out of time.

Ms. Brownley, you have 5 minutes for questioning.

Ms. BROWNLEY. Thank you, Mr. Chair.

And again, I want to thank all four of you for being here today and sharing your story with us. It is extremely important in terms of our work moving forward.

I want to say, certainly as a new Member of Congress, I am a new Member of Congress, and I just want to personally apologize to all of you because we should have done and we need to do a much better job in support of what has happened to you as you have served our country. And your bravery today is to be commended, and your duty as soldiers in the military and your service to our country, but the bravery that you have demonstrated today, I think, is really beyond the call of duty, and I am very, very grateful for your participation.

And there is no question in my mind that there is a lot of work that needs to be done. I mean, we need to address the culture that takes place in the military. That needs to be fixed. We need to address the transition from leaving the service to becoming a veteran. And then certainly, if there is trauma that takes place, then we need to eradicate that from happening in the first place, but if something does happen, then as a veteran who has served our country, we need to figure out how to best provide and service all of you to the very best of our ability and to mimic best practices that are happening outside of the VA, and what is really happening, you know, in facilities across our country when one is sexually assaulted.

So I am not even really sure where to start on the questioning, but I guess, you know, I certainly would like to hear your positions, or your suggestions, I guess, vis-a-vis how we can improve. There has been conversation about sort of case management, so that we, if someone is sexually assaulted in the military, that we transition them with continuity of care to make that transition as best as it could possibly be. But I would just, you know, I offer suggestions, really, from all four of you in terms of, as you have had your own

experiences and knowing what the system is today, how can we improve upon it?

Mr. LEWIS. Thank you, Ranking Member Brownley.

My first suggestion is that fee basis care needs to be made available at the request of the veteran. As our testimony has demonstrated, VA is fundamentally incapable of providing care to survivors of military sexual trauma in the current environment. There are provisions in section 1720B that allow fee basis care to be offered if it is clinically inadvisable, and that is currently the case in a lot of VAs.

I know one VA where male survivors of military sexual trauma are seeking care in the women's clinic. That is not best practice. That is horrible practice. These ladies as survivors deserve a space to be safe and to not be triggered potentially by male veterans. I, in turn, deserve the same place to go and not have—if my perpetrator were a female, which happens a lot more often than we would think, I deserve that same place to go and not potentially be triggered. I also deserve to have, in essence, my manhood respected by not having to seek my care in a woman's clinic.

I also deserve to have a treatment program designed specifically, and that is an area where VA can do a lot more research. There is very little medical literature out there, as I am sure the Chairman well knows, about male survivors of sexual trauma of any sort, and that is an area VA can be leading research and they are not doing it.

The other suggestion I would have is to make sure that there is continuity of care, as the previous question suggested. Just today, I received a phone call from my current provider. He had been out of the office intermittently on and off due to health care problems, but still that makes it difficult. When I returned back from Bay Pines, their facility was to ensure that I received continuity of care. They failed at that. I went for 2 months after leaving Bay Pines without seeing a medical doctor or a psychologist.

What sort of system do we have where we consistently fail our veterans? I cannot in good conscience recommend VA to any survivor of military sexual trauma at this time. Thank you, Ranking Member.

Ms. BROWNLEY. Thank you. Has my time expired?

Mr. BENISHEK. Yes, unfortunately so.

Ms. BROWNLEY. I yield back.

Mr. BENISHEK. Dr. Wenstrup, you have 5 minutes.

Mr. WENSTRUP. Thank you, Mr. Chairman. You know, in the Army we have an acronym, LDRSHIP: Loyalty, duty respect, selfless service, honor, integrity, and personal courage. And, you know, that means addressing wrongs that take place, and wrongs that not only exist in the world as a military, but wrongs that exist within our military. And what has happened to you is literally a form of devastating trauma.

And I know I speak for all my colleagues on this Committee that taking care of our troops is not just a nice thing to say and not just a nice thing to do. It is our obligation to do so. And I really appreciate your courage today, and I think it is up to us to have the courage to change policies and attitude.

My question to you today, and I think I know the answer from your testimonies, but I would like to hear from you directly on this. Do you feel that currently that you would be more comfortable getting care inside or outside of the VA? And I think you just answered that.

Mr. LEWIS. Let's all answer together. Aye.

Ms. SANDERS. Aye.

Ms. JOHNSON. Aye.

Ms. WILKEN. Aye. Receiving care outside of the VA accomplishes a couple of things. One thing that it accomplishes, it puts us in the hands of people who are trained to treat sexual assault victims. Unfortunately, the VA doesn't have a protocol set up to train their employees of how to interact with military sexual trauma veterans, therefore a lot of times they trigger symptoms and make our PTSD worse.

Also, with fee basis being sent outside of the VA, fee basis reimburse at Medicare rates. And so I have a fee basis card. I received that card because I had an unnecessary surgery at our VA hospital in Indianapolis due to a nurse looking at the wrong lab results. And as a result of that my mental health care provider, my psychiatrist, and my GYN and primary care physician wrote consults for me to be able to seen outside of the VA. Originally it was denied. The second decision they approved me to go outside for GYN services, but not for any other services.

When I appealed that decision, then I was given my fee basis card and it says all medical conditions. The difficult part in that is finding a provider in your local area that will accept that fee basis because there is no partnership with the VA. And so if they are a provider that does their own billing, they don't want to see you because they don't want to have to deal with pushing the papers to the VA or waiting for that reimbursement, or if you are a provider and you can bill private insurance \$85 for an hour session, but you are going to get back \$19 for Medicare at the reimbursement rate, would you as a treating physician take that patient on?

And so there needs to be a partnership between fee basis and our local community, and more importantly, also with a national chain of pharmacies. Because when we see an outside provider in your fee basis and you are given a prescription for medication, you have to mail that in to the VA and wait for them to mail your medications to you. A lot of times those medications need to be started immediately. You have the option of going to your local pharmacy and paying for it yourself, but then you are uninsured and you pay the full rate for that medication.

You can then have the VA reimburse you, but as responsible veterans, the majority don't do that. They mail it in, and they wait for it to come back. And it seems as though the VA doesn't look for those commonsense solutions, and that is what I would like to ask the Committee to do today.

Mr. WENSTRUP. Thank you.

Go ahead. Please, go ahead.

Mr. JOHNSON. In speaking very briefly about my employment and time with the women's health program, one of my primary responsibilities was to do outreach calls. And the outreach calls were literally to get numbers for women veterans who are up-to-date on

mammograms and Pap smears, and if they were not, the process for them to go outside of the VA, you know, through fee basis and through working partnerships with hospitals in more remote areas was so simple, I was dumbfounded. But yet there is still no simple way for someone who has experienced MST to go outside of the VA and receive counseling and therapy and medications.

So if we are doing it in one program, that tells me that it is possible to do it for others, too.

Mr. WENSTRUP. Again, that is exactly the type of input that I wanted to get.

Mr. LEWIS. Congressman, one thing I would like to address briefly before your time expires is the use of interns and the use of students, medical students to provide care in the VA. I know at my home VA they are heavily dependent on medical students, and that is simply not a good practice with survivors of such complex trauma as military sexual trauma.

There is a place for medical learning. When I was at Bay Pines, my primary counselor there was a psychology postgrad, and I found her when I was sitting there trying to disclose details of my trauma, sitting there clicking her tongue ring as I was talking about my trauma. To me, that is horribly disrespectful. And another instance at my home VA in Baltimore, a psychology student was running a group and was allowing combat veterans to talk about their trauma while not allowing MST veterans to talk about theirs—it was me and one or two others—because the VA focuses on combat trauma, in her own words.

Quite honestly, there are some four- or five-letter words I could say to that, but for the purposes of the Committee we need to be looking at the proper use of students and residents in providing MST care and we need to be giving a hard look at that. Thank you, Congressman.

Mr. WENSTRUP. Thank you.

Mr. BENISHEK. Thank you.

The gentlewoman from New Hampshire, Ms. Kuster.

Ms. KUSTER. Thank you very much, Mr. Chair, and thank you to all of the Members of the Committee for convening this hearing. I was one of the Members that requested that this happen, having spoken to veterans in my area, New Hampshire.

One message I want to convey, along with Ms. Brownley and Mr. Wenstrup and Ms. Walorski and Ms. Kirkpatrick, is that we are recently elected, Ms. Kirkpatrick coming back, but we are new Members to Congress and so we are arriving here right at a time when the public is very focused on this issue. And I want you to know that we are going to work with Ms. Speier, who has been working on this issue for a long time, and with a number of other colleagues in both the House and the Senate.

I really appreciate the chair for holding this hearing. This is a significant issue, and we have made a real strong commitment to work in a bipartisan way. And I want to thank my colleague, Ms. Walorski, for leading what was truly an extraordinary effort on this whistleblower protection, and I want you to know that we take that very seriously. We passed that bill 2 weeks ago 423-0 in the House. That is the kind of support you have when we come together and find common ground. So I know that we can help you,

and I join Ms. Brownley in apologizing to you that you haven't been heard previously.

So my question, I have been trying to jump start my education on this by going and visiting facilities. New Hampshire is the only State without a full service veterans hospital, but fortunately, we share the hospital in Vermont, White River, Vermont. They have a brand new, newly opened care center. And I hear, Mr. Lewis, your concerns, and I want to address that. But in this case, it is a brand new women's support center where they have listened to victims and survivors about literally the architecture, but particularly the programming that they want. I also visited a Manchester veterans center where they have really outstanding treatment and provision of counseling and groups and such there.

And so I want to ask you, I respect the recommendation for care outside of the VA, and if that is the direction we go, then that makes sense to me, because I understand we can't bring the training up all across the country. But if you were in a position to advise us of what best practices would look like if we could get to that place in the VA system, what is it that you would recommend be included? And this would be either in a hospital setting, in a med center, in a vet center setting, in a clinic setting, what are the components that you would recommend to us?

Mr. LEWIS. Congresswoman, I appreciate the question. And to hear about the program at White River Junction, quite honestly, almost makes me want to cry.

Ms. KUSTER. It was truly incredible, and I was given the tour by a victim that had been a part of a task force and they had addressed a lot of the issues that you are talking about including, you know, literally, the entrance, making sure that it is glass, that the women can see who is coming in. The only treatment providers are female in that entire section. And so what are some of the elements that we could be addressing?

Mr. LEWIS. I will defer to some of the women veterans sitting here to talk about the components of the women's veterans program, but I think that the first thing that White River Junction would do, to bring it to your area, is to do that same thing for male survivors. We don't deserve to have to walk through the same sea that the women veterans have complained about and be looked at in a demeaning tone because we are not combat veterans. We also don't deserve to be mixed in with the women only because VA cares that little about male survivors.

Other components that I would suggest is MST programming needs to be conducted in mental health. As a man, if I go to women's services, they are triggered, I am certainly triggered because I feel a lot less than a man being respected as a survivor. I would also recommend getting away from the current practice of teaching by the manual and hoping our objective scores go down. That is not right. It is an experience, it did cause psychological damage, and it deserves to be looked at holistically, not out of a manual where you go from one method to the next, to the next.

And that takes a whole-person concept. That takes peer supporters. That takes a whole range of things. And I would be happy at some future point to talk to you about that, and I will defer to the lady survivors here about the women's side.

Ms. SANDERS. I would like to see satellite clinics. My mother lives in Kansas. They have a satellite clinic that comes. It is only a distance of 35 miles to the hospital. But twice a month they come, and so the people can come to that satellite clinic and get their medications renewed or get whatever it is they need. And I think that that model should be used for military sexual trauma. I think that if you could say on Mondays we have a women's clinic at this address where it is not the VA, and it is just for women, or men, and you can rent a room, it is inexpensive that way, you are not building a facility, we are not asking you to build us the Taj Mahal, we are just asking you to provide us a safe space close enough to our home that we feel comfortable in going that distance.

For me, an hour away is too far at this point. I can't make it. The vet center in my county has one man that works there, and he can't even answer the phone because he is so busy. He is afraid to work with female survivors because he is afraid, because he is a big body-building man, that they are going to be afraid. When I came out in the newspaper we had a long discussion and he said, I am afraid of what will happen if you come out in our local paper and women call expecting there to be a woman here. And there isn't.

The vet centers need to be supported, and the idea of a satellite clinic needs to be explored, which could eliminate some of the fee basis. If you take the trained people you have, send them to Trinity County for Wednesdays and Humboldt County for Tuesdays and provide the care where the people are. I was a nurse and I was taught, you always meet the patient where they are. You do not expect the patient to come up to wherever you are. I said in my written testimony, at times it feels like you are saying to us, if you get close enough, I will fix that broken leg of yours, but until you walk over here, I can't help you.

Ms. KUSTER. Right. Thank you.

Mr. Chair, I have gone over my time.

Mr. JOHNSON. Could I add one more quick comment? While I agree with the other witnesses here, and their suggestions, I think it goes back to basics too. I was never asked. I was never screened.

Ms. KUSTER. Right.

Mr. JOHNSON. I was never given the opportunity or that trust-building period to disclose my experiences, for whatever reason. If you can't get your foot in the door and doors keep slamming in your face, you are either going to give up, you are going to go elsewhere, or something worse is going to happen.

So I really think we need to look at the basics, and start with consistent—I am reading testimony from, you know, others that are going to talk today saying MST screening, MST screening. In my experience, I didn't receive that. So if we can find a more consistent—

Ms. KUSTER. Yeah, that needs to be the standard.

Mr. JOHNSON.—then we can get in the door and then we can decide where the treatment is coming in. But we need to look at the very, very beginnings of putting that first step, putting your foot into the door of that VA hospital, the people that are supposed to know everything and help you.

Ms. KUSTER. Thank you so much for your courage.

And thank you, Mr. Chair, for your indulgence.

Mr. BENISHEK. The gentlewoman from Indiana, Ms. Walorski, you have 5 minutes.

Mrs. WALORSKI. Thank you, Mr. Chairman.

And again, to you all for coming today, thank you so much. I would like to echo what Representative Kuster was saying. We are committed to eradicating sexual trauma in the military. And we are new, and we are all young Members here, but our passion and our commitment to you today is that, you know, the bravery that you have exhibited by being here today, the courage on shining a light in the darkness makes a difference. We get calls every day now that we have talked about this from the time we have been here, every day there are new people coming forward and sharing their stories. And your stories are going out today around the country, and that is why we are thankful that you made the trek. And just to let you know that we are standing with you and we are fighting for you. And thank you for your service to our Nation. It is our turn to fight for you, and you have my commitment to continue to do this until we eradicate this from our military.

Lisa, I wanted to ask you particularly because you are well informed and you have made it a mission in the State of Indiana to find out the scope of the weaknesses, the strengths of the VA. How would you describe, overall, in the State of Indiana, treatment for MST victims as you pursued it, not only from your perspective, but because you know, you have a wealth of information about how our State runs? How would you overall say the conditions are with treatment of MST?

Ms. WILKEN. Overall, in the State of Indiana, if I had to rate it on a scale of 1 to 10, I would give it a 3, because they are making an effort. We have a military sexual trauma coordinator at the VA medical center in Indianapolis who is wonderful, but she is one person. We need more services of what has been talked about today, whether it is satellite clinics or using outside treatment facilities, but the issue needs to be addressed, not only on a State level, but on a national level with you here today.

Mrs. WALORSKI. I appreciate it. And also if I could follow up on that, Lisa. And I can just tell you the information we have heard from here today is tragic. It is just such a tragic story. And so we hear all these stories and we see all the data and we are listening to you. There is such a growing need to treat victims of MST.

Why do you think, Lisa, as you have gone through this maneuvering process, what do you think the biggest issue is with the VA being so resistant to this information, and despite the pleas from veterans, thousands of veterans around the country?

Ms. WILKEN. I wish I could answer that and give you an answer of why, but I can't answer that because it doesn't make any sense to me. If the treatment is already set up in your local community or you have avenues in your local community, but the VA doesn't have the services available, common sense would tell you, treat the veteran, treat the survivor, and we are not seeing that right now. And so going out into our local communities, while the VA is developing their process, would be something that would be beneficial.

Mrs. WALORSKI. And let me ask you this. You know, our hope is—we passed this whistleblower protection law, as you are famil-

iar with, and you were a helpful story with that as well. With whistleblower protection, you know, hopefully being valid and signed into law in January of 2014, and if we can move this Congress to get those outside services and those things provided outside of VA, do you think we will see an influx of folks reporting because they will feel like they have a safe haven on one end in the military from retribution and on the second side not be incumbent upon going to the VA for services that don't exist?

Ms. WILKEN. I think you will see MST veterans and survivors come out the woodwork. There are men and women across this country who wore the uniform and were proud to serve, but haven't been proud of their service because of the experience they had, and if you give them the opportunity to give them skills to deal with years of unattended PTSD symptoms, I know these men and women will reach out and want to help themselves and their families.

Mrs. WALORSKI. I appreciate it.

Anybody else want to crime in? We have 50 seconds.

Mr. LEWIS. Thank you, Congresswoman. You asked earlier about treatment at VA. One of the main problems is there is simply too few providers. I go to the Baltimore VA, and we are talking a big city here, and there are very few MST providers that are specifically trained in this area. You have heard of all of us talk about our MST coordinators. It is a collateral duty. At a big city VA, even at the smallest VA, that is a full-time job. I guarantee you, we could fill this room to overflowing with veterans who could talk about horrible treatment at the VA, and we are giving this collateral duty to one person. That is wrong.

So let's get a lot more people in there that are trained and are willing to provide quality care, and let's get researchers in there that are willing to do the research, especially with male survivors. Thank you, Congresswoman.

Mrs. WALORSKI. I appreciate it.

Thank you, Mr. Chairman.

Mr. BENISHEK. My colleague from California, Dr. Ruiz.

Mr. RUIZ. Thank you very much, Chairman.

I first want to say, thank you so much, Ms. Sanders, Ms. Wilken, Mr. Lewis, and Ms. Johnson for having the courage to come up and tell your story once again. And I want to say how very proud I am that today you have given voice to so many women and men who have suffered this atrocious experience.

It is a triple assault that many of our veterans face. One is the trauma of war or the trauma of feeling that they could die at any moment through an experience from war, which is PTSD related. The second is the trauma of the MST experience. And what I am hearing now is that we have a third incident, and that is the trauma of the lack of coordinated, sensitive, and appropriate care.

That as a physician sometimes I know that the treatment can make things worse. And so as a physician, it is absolutely unacceptable. As a congressman, it is absolutely unacceptable. And I know I speak on behalf of everybody on this panel, I know the hardships that many patients face, men and women who come to the emergency department because of sexual trauma.

I agree that sexual trauma is a holistic illness that is not something acute that can be treated with a pill. It is not a one-time shot. It is not a one-time treatment. It is a lifetime struggle. And part of the illness of this is the sense of powerlessness, and part of the treatment is to regain that power as an individual, to be empowered, to feel like you are back in that control room. And so I appreciate it because what you are doing today is giving that empowerment to a whole lot of people around our country, and I thank you for doing that.

A side victim in all of this is the family and relationships that you have with your spouses, your significant other, your children, issues of trust, issues of being able to communicate. And I know that it is very difficult. Has the VA addressed treatment with your significant others, your families, and your closest friends?

Ms. WILKEN. I will answer that. Not to my knowledge. I don't know that there is any type of program set up for family members, spouses, or children. But thank you for bringing that up. It is something that most certainly needs to be addressed.

We all talk about it as military sexual trauma. We are all rape survivors. No one wants to use the word "rape" because it brings with it all the ugliness that rape brings into your life. It was brought into our lives, and we brought that into our family's lives, and our families need support. They are our biggest support network. Issues need to be addressed with our significant others and with our children. It could be modeled after an Al-Anon program who gives support to family members of alcoholics. We need that support so that we have a strong support system. They need a support system also.

Intimacy issues need to be addressed. That is something that we don't like to have to talk about, our intimacy issues that we have with those who have stood by us and who have loved us through this process, but it is important and they deserve that. And so if I could ask the panel to take a look at that issue, it needs to be done.

Mr. LEWIS. And if I could follow up on that?

Mr. RUIZ. Yes, sir.

Mr. LEWIS. A significant barrier in that is veterans who are identified as gay, lesbian, bisexual, transgender, services in that department can be very difficult. I do know the VA in St. Louis, through the work of Terri Odom, is starting in that area, but it is not a national trend yet and that really needs to be addressed, because there can be a lot of gender confusion, a lot of sexual confusion after a sexual trauma, and that really needs to be addressed.

And I would also like to pick up on your point about survivors having power again. A lot of times the VA takes our power away from us or asks us to use it in inappropriate ways. I was asked to take a nerve block to relieve some of my chronic pain, and I was asked to take this nerve block transrectally. Imagine a mail survivor being asked to take a nerve block with a doctor. You are in an OB/GYN chair. Your legs are up, and you are having something inserted through your rectum and pushed into a nerve in your prostate to remove your pain. That is the type of pain I live with.

My psychologist would not step in knowing what that procedure would do. That power should not have been needed to be exercised

by me. That should have been my psychologist stepping up and saying, no, this is contraindicated. So sometimes that power is used in both ways.

And you are right, Congressman. You know who was there for me? It wasn't the VA. It was not anyone at the VA. It wasn't even the doctor that gave me the injection. It was my partner that got me out of that building. And he gets no recognition from the VA for that effort. And they need it badly. Thank you, Congressman.

Mr. BENISHEK. Thank you.

My colleague, Dr. Roe, 5 minutes.

Mr. ROE. Yes. I thank the Chairman.

And thank you all, the entire panel, for being here today.

You know, I go back as a young military medical officer during the Vietnam era, and I was thinking, as I was listening to the testimony, what training I had had, and I am an OB/GYN doctor, and what training did I have going into the military as a drafted doctor and what training did I get in the military to treat this.

And I can tell you, in the military I received none, and one of the reasons was military sexual trauma was occurring, it didn't start now, it has been going on, but it was not recognized. I mean, I never heard it mentioned. And just logically thinking about it, you knew it occurred outside the military, why in the world wouldn't it have occurred in the military. But it was one of those, I mean, if you just think logically about that, why all of a sudden one day I am out in the civilian world and I get drafted and sent in the military and the next day it is not an issue.

In today's military there are a lot more women serving. I have been to Afghanistan with Dr. Benishek and others, and it is amazing how many women now are doing a phenomenal job in the military. And so there is that issue there. And I think what we have to do as a scientist, you identify the problem, you identify and try to determine what the incidence of that problem is, and then you try to find a solution to that problem.

And I think, Ms. Sanders, you brought up something—and I don't think the VA has ever been equipped to do that. I look at my—we have a VA medical center in my hometown, and it is woefully undergunned in this. I can tell you right now. There is no way on this earth they are prepared. It doesn't mean that those folks are not willing to do it. It just means that they are not prepared to do it adequately right now.

I think Ms. Sanders as a nurse brought this out very, very eloquently in your testimony—or answer, I should say—is that you want to get that chair to as close to home where you feel safe and so forth as you possibly can. It is intimidating enough to go a doctor's office or to a large medical center. I mean, I am going to have a physical next week, and I have already got sweaty palms about it, and I have done thousands of them. So I understand exactly what you are saying.

I think either we take the treatment to the patient, but as Dr. Ruiz said, you can't take the wrong treatment to the patient. You have done them harm, not good, as Mr. Lewis pointed out. So I think we identify the problem and then look for victims, like yourself, who have suffered military sexual trauma, and come up with a plan of how to better treat these patients, and right now we don't

have it. And whether it is, as Ms. Wilken says, outside the VA, if that is where the best therapy, that is where the patient should be able to go, where they get the best treatment.

And I guess, Ms. Johnson, I was looking at your testimony and you have said that the treatment you received at the Madison, Wisconsin VA was extremely limited, and what did you mean by that?

Ms. JOHNSON. It had to do with the fact that I was not yet service-connected, so I was continuously told that I couldn't receive consistent treatment there until my service-connection came through.

Mr. ROE. Okay.

Ms. JOHNSON. That being said, the problem with that was that MST was never addressed, so who knew that that was part of the issue.

Mr. ROE. Never connected the dots.

Ms. JOHNSON. Exactly. Not through, you know, my primary care physician when I started having GYN issues, to include emergency room visits, not mental health. And as I said in my oral testimony, I was not a combat veteran. So to have all of these symptoms going on and still not be screened for MST, so that I could receive treatment and therapy while waiting for my service-connection really put me behind, and it was really a travesty because every time I had to go there, I built myself up for a week before saying, I am going to tell my story, this is it, I am going to be able to do it, and then I would be deflated. And then it would take me another week to really come down from that experience. And, you know, it was different providers every time I went. The most often I had ever seen the same provider was twice.

Mr. ROE. I think you hit the nail. I stayed in the same spot for 31 years before I was elected to Congress, and I have had patients that I had known for 20 or 25 years that finally told me something after 25 years, and it was like—I mean, they knew me well and knew me very well and had seen me, and maybe I delivered their children, whatever. And it was like a load of bricks being lifted from their back. And I think you could see their life open up in front of them. And I didn't see that one time. I saw it multiple times.

And as I point out to you all, I did numerous sexual trauma evaluations on patients that had been assaulted in the private sector. And as I think back to my time and the 2 years I spent in the military, I didn't do a single one. You know it was there, but it was just so under the carpet, nobody talked about it. I think the fact that you all have done that have really been helpful, maybe the most helpful thing, and I think the other things you all can do is give us ideas about how we can help the VA be better.

And we found out how doing it not right for you individually helps, and I suspect that your story is not that much different. Everybody is an individual, but still there is a common theme here that I am hearing.

I yield back, Mr. Chairman. Thank you.

Mr. BENISHEK. Thank you.

Mrs. Kirkpatrick.

Mrs. KIRKPATRICK. Thank you, Mr. Chairman, for holding this hearing.

Thank you, Ranking Member Brownley, for this opportunity to hear from you.

And thank you for showing up and your courage to testify before Congress. I am just so sorry for what has happened to you.

I am a former prosecutor. I have prosecuted rape cases, and I just want to know if any of your perpetrators were ever charged.

Ms. WILKEN. My perpetrator was charged. I went through the Article 32 hearing, which is the equivalent of a grand jury hearing, and he was charged with five charges. Went through the rest of the investigative process, and he was given an other than honorable discharge in lieu of court martial.

The special prosecutor that was brought in from the 12th Air Force to prosecute the case on Offutt Air Force Base explained to me the night before we were headed to trial the next morning, they called me in for another meeting, and sat me down and explained that, Lisa, I can prove that he raped you, but the rape wasn't violent enough for him to get any real jail time. And what this gentleman was doing was giving me a message of what I was in for the next day. He knew what I had been through, through the investigation and the Article 32 hearing, but that was his compassionate way of letting me know that we can go forward with this, and we can prosecute him, but what they are going to do to you in the meantime is not at all going to compare to what they do to him.

But he would not agree to giving him an other than honorable discharge unless I agreed to it. And I was 22 years old at the time with no victim advocate because they didn't allow them on the base at the time, and I agreed, because I knew what I was in for, and if it wasn't going to result in him getting any jail time, there was no reason to put myself through that.

So they had him processed and out of the United States Air Force and off base within 1 week, and then I found out that he had attempted to do the same thing at his previous base. So they put a repeat offender out into the civilian world with no criminal history.

And so it is important that you are having this hearing today so that victims have an opportunity to realize that people are listening now, and hopefully, we can make a change so that someone younger than myself doesn't have to make the same mistakes that I have made over the years trying to deal with PTSD.

Mrs. KIRKPATRICK. Thank you for sharing that with us.

And you know, Dr. Ruiz, I just want to add to your list of traumas. I think there is a fourth trauma here, and that is that these perpetrators got away with it, and there has been no justice. And I suggest to the Chairman and Ranking Member, maybe that is a topic that we could have a future hearing on because, you know, they got away with it, and that is just not right. And again, I am so sorry.

Ms. WILKEN. And if I might, the decision, you being a former prosecutor, the decision of which cases get prosecuted right now is currently in the chain of command. That is something that this Congress is hopefully going to continue to take up. The Whistle-blower Act is a wonderful thing that is out there so that victims can feel confident that if they do decide to report, that they won't

be retaliated against. But common sense again tells us, if you can't get a commander to prosecute rape, a crime of violence, why would a victim have any confidence that that commander is going to protect them when they come forward? So thank you for bringing that topic up. It is important.

Mrs. KIRKPATRICK. That is exactly my concern. Thank you very much.

Mr. LEWIS. Ms. Kirkpatrick?

Mrs. KIRKPATRICK. I yield—go ahead. Yeah.

Mr. LEWIS. If I might, Ms. Wilken is very—I hate to use the wrong word here, but she has seen some measure of justice. A lot of survivors really do not see justice at all. I know in my case, I was threatened under the “don't ask, don't tell” policy, and that is a huge concern, especially in the veteran—in the male survivor community, is that we were told, if you go forward with this, you will be outed as a gay man, regardless if you are or not, and pushed out of the military, or you will be given some sort of weaponized diagnosis like personality disorder or border line adjustment or whatever.

Another aspect of your question is the current process to change your discharge. The military's favorite line is, if this person is dissatisfied with their discharge, tell them to go to the Board for Correction of Military Records. I am here to tell you that is a joke, and that is really deserving of this Congress' attention. Less than 10 percent of all upgrade petitions are adjudicated favorably. Imagine the psychological damage that does to a veteran when they get—first off, they are traumatized in the military, then they have to go back to the military and say, we were hurt, we deserve our PTSD because these people rated us as at 100 percent and these people gave us a general discharge. And then the military says, oh, no, we were totally right in doing it.

That is another area that totally needs to be addressed, and that is also a good reason to pass H.R. 1593, the STOP Act, just as quickly as possible, is to stop some of those actions and to really enforce the whistleblower laws, because if you go ahead, especially in the military, you are going to be pushed out and then you are going to be told you can't get your discharge changed. And that has implications in the VA for receiving care. Thank you.

Mrs. KIRKPATRICK. Thank you very much. I yield back. Thank you, Mr. Chairman.

Mr. BENISHEK. The gentlewoman from New York, Ms. Speier.

Ms. SPEIER. Actually, it is California, Mr. Chairman.

Mr. BENISHEK. California. Oh, sorry, bad advice.

Ms. SPEIER. The other coast. Mr. Chairman, thank you, and Ranking Member Brownley, thank you as well and all of the Members for showing such a deep and committed interest in this issue.

To you survivors, you are American heroes, and we owe you a great debt of gratitude, because you are speaking on behalf of 500,000 veterans who have been sexually assaulted, raped, in the military. I want to ask you a series of questions so that we can get a sense, because I think I know the answers, but I think it would be important for all of us to go beyond the numbers.

Eighty-seven percent of victims don't report, and they don't report for a very obvious reason: Because they don't get justice. So,

let me ask this. How many of you were raped early in your military careers?

How many of you were under the age of 25?

How many of you were under the age of 20?

Mr. LEWIS. I was 20.

Ms. SANDERS. Twenty.

Ms. SPEIER. How many of you were raped multiple times?

Ms. SANDERS. Pardon?

Ms. SPEIER. How many of you were victims multiple times of rape?

Ms. SANDERS. No.

Ms. SPEIER. How many of you were sexually harassed?

How many of you endured an Article 32 hearing? Now, an Article 32 hearing in the military allows the defendant's attorney to question the victim about their prior sexual history. Now, we have rape shield laws in this country that prevent that from going on in civilian society, but in Article 32 hearings they are able to raise that.

How many of your assailants were in the chain of command?

All right. This is really important because this makes the case that if we keep it in the chain of command, the likelihood of any victim getting the kind of fair evaluation, it is just not going to happen.

How many of you were your assailants associated with, or friends of, or known by someone in your chain of command? So in your case, Ms. Wilken, you are the only person that was raped outside your chain of command, it looks like.

How many of you were treated only by medication?

How many of you were overly treated by medication?

How long after your assaults, your rapes, were you discharged?

Mr. LEWIS. One year.

Ms. WILKEN. Two years.

Ms. SANDERS. Nine months.

Ms. JOHNSON. Ten years.

Ms. SPEIER. How many of you have a DD-214, which indicates that you have a personality disorder, adjustment disorder, or something like that?

How many of you believe that for this issue to be dealt with appropriately in the military we have to take it out of the chain of command?

All right. How many of you, when you entered the VA system, were asked specifically, if you had been raped or sexually assaulted in the military?

How many of you received one-on-one counseling?

Ms. SANDERS. What?

Ms. SPEIER. One-on-one mental health counseling in the military.

How many of you were in a sexual—an MST program that was reflective of your gender?

Ms. WILKEN. It was also—it was a rape survivor and incest survivors group. They put us together.

Ms. SPEIER. Okay. Very briefly, if you could, speak about the violence in your rapes, because we tend to overlook that because we focus on the numbers, and most of these rapes have a level of violence that we have no conception of.

Ms. SANDERS. I was pushed into a room by three men. One of the men got inside with me, he pushed me down, he tore my pants, he—you know, there was evidence that they could have collected, but he was given nonjudicial punishment.

Ms. SPEIER. And you were locked in that room, were you not, by the two other—

Ms. SANDERS. I was locked in that room by the outside. There were two padlocks on the outside doors, and his two friends were not to open it until he said so.

Ms. SPEIER. Ms. Wilken.

Ms. WILKEN. Some people might say that I am a lucky victim, that I was asleep when the assault started, so I woke up to it happening. So there are parts of the assault that I wasn't awake for but that were evident. And so a lot of people think that if you are not aware of the assault, that it is not as bad, but rape itself is a crime of violence, and to have someone put their hands on your, or be able to put themselves inside of your body without your permission in itself is violent. And so a lot of people think that it is not as bad if you don't know exactly what happened to you, but not knowing sometimes makes it worse.

And to bring up the point that you talked about, about using your sexual history against you. In my case, during the investigation, I was interviewed by the Office of Special Investigation that does things in the United States Air Force. I was interviewed for 4 hours in an 8-by-8 room with two male OSI officers, and I had to go through my entire sexual history from the time I lost my virginity until the night that I was assaulted, and I had to answer questions about that at the Article 32 hearing. And so it revictimizes you.

Ms. SPEIER. So my time has expired, but Mr. Chairman. Is it all right if the last two witnesses?

Mr. BENISHEK. There is a little time for more.

Mr. LEWIS. My perpetrator used a weapon to obtain my compliance. He used a knife. Had I resisted, I would not be here. I would be 6 feet under, and I knew that looking in his eyes.

There is a lot of victimization that goes on physically and mentally when senior members of your chain of command come down and say you will not file a report, official report with Naval Criminal Investigative Service. That is a victimization almost as bad as the one. I don't remember a whole lot because my perpetrator hit me over the head and knocked me unconscious. I have been trying to get evaluated for head issues ever since, and VA has never done it.

So there is physical violence and there is the violence that comes after when your command says you are not going to do this, and then the doctors in the military say, oh, you are fine, let me push you a boatload of pills and send you back out to sea. Or the doctor that we go to in the military that says, oh, you are lying about what happened, and by the way, here is your personality disorder and a bag of pills to last you 90 days on your way out.

I took enough pills when I was stationed at 32nd Street in San Diego to float a ship. I often called it a shuffle, because I didn't feel my feet could touch the floor. And that is violence as well, and I

know you meant the physical kind, but that violence needs to be addressed as well.

And there is no gender-sensitive care for male veterans anywhere. That is why me, and a few other survivors, are standing up Men Recovering from Military Sexual Trauma, because men don't have anywhere to go. We are emasculated when we have to talk about this and we don't deserve that in this culture. Men deserve the right to be supported, too.

Thank you, Congresswoman.

Ms. JOHNSON. My situation was as a young officer candidate, and it was actually out in a social situation that it started. And for many years, I did not disclose it, because it was more of a date rape situation, and I was told afterward, you know, that I pretty much deserved it and brought it on myself. And for whatever reason, I sincerely believe that I was given something so that I wouldn't remember or so that I would be more compliant.

Growing up in New Jersey, being a Marine, I am not a very compliant person anyway. But I don't remember much of it. But if someone comes too close to me or I feel that someone invades my personal space, or I smell a certain kind of smell, I become so agitated and scared to the point where I can't function, and I feel like I am going to throw up. And that can happen anywhere. So while it wasn't really—I didn't come out with bruises. I came out with pain and I came out with invisible wounds.

When it happened years later with somebody else, it was sort of the same situation, and I was told, well, it is not rape. But I said, no, no, it is not rape. And so while neither incident was outright violent, I was not physically harmed in such a way as the other witnesses, it still—the violence in it for me was questioning my judgment and questioning who I was as a person and believing for so long that it was my fault and that I couldn't tell anybody.

And how you think at 22, and how you think at 40, when you are trying to raise two young men, really impacts the way you look at things. And when I knew, I said would I want one of my sons to treat a woman like that or that to ever happen? And my answer to myself was, absolutely not. And at that point I knew that, you know, what I had experienced, and I was still traumatized from it and that it was wrong. So completely different situation, but long-lasting effects.

Ms. SPEIER. Thank you.

Mr. CHAIRMAN. Thank you for your indulgence.

Mr. BENISHEK. I want to thank you all so very much for coming to Washington and telling your stories. You have been very helpful to us in trying to correct this problem. It is particularly frustrating to me to hear these stories one after another. And while your individual experiences are unique, the challenges and barriers that you spoke of in facing VA and DoD are very similar. I hope that the administration officials in the audience were listening as closely as I was to your testimony.

Thank you very much, and you are excused.

Ms. SANDERS. Thank you.

Mr. BENISHEK. I would now like to welcome our second panel to the witness table. Joining us on the second panel is Dr. Michael Shepherd, a physician at the Office of Health Care Inspections at

the VA Office of the Inspector General. Dr. Shepherd is accompanied by Karen McGoff-Yost, the Associate Director of Bay Pines Office of Health Care Inspections. Also on our second panel is Dr. Jonathan Farrell-Higgins, the Chief of the Stress Disorder Treatment Program at the VA Eastern Kansas Health Care System, and Carol O'Brien, Chief of the Post-Traumatic Stress Disorder Program at Bay Pines.

Welcome.

Dr. Shepherd, 5 minutes for your testimony.

STATEMENTS OF MICHAEL SHEPHERD M.D., PHYSICIAN, OFFICE OF HEALTH CARE INSPECTIONS, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY KAREN MCGOFF-YOST LCSW, ASSOCIATE DIRECTOR, BAY PINES OFFICE OF HEALTH CARE INSPECTIONS, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; JONATHAN M. FARRELL-HIGGINS, PH.D., CHIEF, STRESS DISORDER TREATMENT PROGRAM, COLMERY-O'NEIL VA MEDICAL CENTER, VA EASTERN KANSAS HEALTH CARE SYSTEM, VETERANS INTEGRATED SERVICE NETWORK 15, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; CAROL O'BRIEN PH.D., CHIEF, POST TRAUMATIC STRESS DISORDER PROGRAMS, BAY PINES VA HEALTHCARE SYSTEM, VETERANS INTEGRATED SERVICE NETWORK 8, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF MICHAEL SHEPHERD

Dr. SHEPHERD. Mr. Chairman, Ranking Member Brownley, and Members of the Subcommittee, thank you for the opportunity to discuss our recent IG report on residential treatment for female veterans with MST-related mental health conditions. I am accompanied today by Ms. Karen McGoff-Yost, Associate Director in our Bay Pines Office of Healthcare Inspections.

I first want to also thank the four veterans on the first panel for their courage in sharing their experiences and their insights. I want to briefly mention why we did this review and offer a few observations.

This inspection was undertaken in response to a request from the Senate Veterans' Affairs Committee. The report was intended to describe the care of female veterans discharged during the 6-month period from 14 programs listed by VA as having the ability to treat mental health conditions related to MST. Although the request and the report specifically focused on treatment of female veterans, I do want to acknowledge the incidence and distressing impact on both male and female survivors.

In terms of the age range and service era of program participants, somewhat surprisingly, the average age was 44, with the 46-to 50-year-old age group as the most common. Four percent of the patients were under 25 and a quarter were OEF/OIF veterans, with the remaining three-quarters other service era veterans. And I think this demographic data highlights the impact across service eras and also highlights the pressure on the system to simulta-

neously plan for and serve the growing mental health needs of recent vets and also aging other era vets.

Second, I want to comment on the clinical complexity of patients served by these programs. Ninety-six percent of the patients in our review had two or more mental health diagnoses in addition to multiple physical diagnoses. In fact, 8 percent had concomitant eating disorders. After treatment in these programs, patients tended to return to the clinic and facility at which they received pre-program care; 22 patients were readmitted to either an acute mental health unit or to another residential program.

For me, the real takeaway is that for these patients, effective treatment is not a linear one-stop in an intensive program and done solution, but rather requires a coordinated and longitudinal effort, building the foundation of care in the outpatient setting, having adequate coordination forward to optimize residential treatment, and then integrating treatment back to the outpatient setting to effectively build on gains achieved.

Third, largely, all but three programs treated patients from all over the country. There was a national draw to these programs. On site visits, though, we found that difficulty obtaining travel funding authorization was a consistent theme. MST policy dictates care for veterans, even those not otherwise eligible for VA services, and that residential MST care should be available. But VA's travel beneficiary policy is restricted to veterans meeting certain eligibility requirements and favors treatment at the nearest facility.

We found the two policies do not align. For some patients, this lack of alignment may delay program access. We recommended the Under Secretary review existing policy pertaining to authorization for veterans seeking mental health MST treatment in these programs. VHA concurred, established a work group to review issues and provide recommendations. As of the last quarterly update, the work group was continuing its review of this issue.

Finally, on site visits, MST coordinators consistently reported their concerns that given their direct patient care responsibilities, they did not have time to perform their collateral MST coordinator duties, including outreach, coordination, and tracking of patients with positive MST screens.

In conclusion, the programs reviewed do serve clinically complex patients who come for treatment from across the system. Ideally, these women and men would be engaged in a coordinated, integrated, comprehensive, and longitudinal treatment effort.

Mr. Chairman, thank you again for this opportunity to testify. I would be pleased to answer any questions that you or Members of the Subcommittee may have.

[THE PREPARED STATEMENT OF MICHAEL SHEPHERD M.D. APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Dr. Shepherd, for your testimony.
Dr. Farrell-Higgins, you may proceed.

STATEMENT OF JONATHAN M. FARRELL-HIGGINS

Mr. FARRELL-HIGGINS. Good afternoon, Chairman Benishek, Ranking Member Brownley, and Members of the Committee.

The Eastern Kansas Health Care System is comprised of two medical centers 65 miles apart, nine community-based outpatient clinics, and is a tertiary psychiatry facility. I am the chief of the Stress Disorder Treatment Program, a 7-week inpatient unit for veterans with post-traumatic stress disorder and other stress-related problems. This 24-bed unit is designed to help veterans deal more effectively with traumatic experiences that occurred during their military service. The unit is physically located within the medical center at Topeka.

As program chief and as one of two PTSD mentors for VISN 15, I am pleased to share my reflections from the field concerning MST treatment. Our Topeka program is best described as an integrated mixed trauma model for mixed gender. We provide inpatient treatment services for male and female veterans from all branches and all areas of service, as well as active duty military personnel.

Trauma issues addressed include those related to combat, MST, nonsexual assault, and training incidents. The unit is designated as a national resource Specialized Inpatient PTSD Unit, or SIPU. The program's overarching treatment goal is to help veterans maximize their post-traumatic growth and recovery with ultimate reintegration back into families, workplaces, and communities.

Here is some key program data. In fiscal year 2013 to date, the unit has treated 119 patients; 28, or 24 percent of these patients self-identified at admission as MST survivor referrals. Additional, patients self-identified after admission as having sexual trauma issues, in addition to other presenting trauma issues. One hundred percent of the identified MST admissions have had a PTSD primary diagnosis.

More MST admitting cohorts are already scheduled for admission in the fourth quarter. Of the fiscal year 2013 MST referrals, 24, or 86 percent have been men, and 4, or 14 percent, have been women. MST patients include those who served in Vietnam, Iraq, Afghanistan, and other locales.

Of our MST referrals, males heavily outweigh females, outnumber. As is common in other inpatient and residential programs, we experience a higher percentage of MST admission no-shows and cancellations than for other traumas. This speaks to multiple issues, including high comorbidities, readiness issues, and travel difficulties.

The program is staffed 24/7 by a terrific multidisciplinary treatment team. They provide multiple evidence-based psychotherapies, gender-specific care, same-gender therapists, diverse psychoeducational programming, complimentary alternative medicines, or CAM, such as yoga, mind flush meditation and exercise, and medication management.

As a national resource program, MST referrals are nationwide. A rolling admissions format is employed wherein MST referrals are admitted in many cohort groups in order to provide for maximum comfort and group cohesion. In fiscal year 2013, we have not encountered any aborted on-site admissions due to safety, comfort, or acceptance concerns.

Treatment highlights include these things. First, the program's core value of treating diverse individual works. MST is destigmatized by virtue of side-by-side trauma treatments. MST is

not regarded as a second class source of PTSD, but as a primary problem in its own right.

Second, the program achieves a powerful sense of community and acceptance of all individuals with PTSD regardless of gender and trauma demographics. The in vivo aspect of the treatment environment is normalizing, essential to veterans' recovery efforts, and facilitates reintegration into the real world.

Third, treatment outcome data supports the mixed trauma model. Outcome data for MST patients are comparable to non-MST patients for PTSD, anxiety, and depression symptoms.

Last, treatment gaps and challenges include these. First, active duty personnel. Our program is 1 hour from two military installations and we receive active duty referrals for combat trauma treatment. However, referrals for MST are infrequent. Patients report fear of stigma and concerns about career advancement. These are worthy issues to be further addressed.

Transportation. Some MST referrals have struggled with transportation problems to our program and to other programs. One non-VISN female veteran who could not afford transportation to our program was eventually flown to and from our site by a volunteer veteran support organization. Beneficiary travel policy and MST policy must work together so program access is not a problem.

Capacity. Greater understanding is needed of the multiple factors that contribute to unfilled MST beds. MST specialized programs are encouraged to share best admission practices that improve bed utilization.

And last, research. More multi-site, multiprogram research is needed to best discern the critical treatment components that yield the most robust treatment outcomes.

In closing, I am pleased to be part of the growing national efforts to treat MST, and I appreciate the opportunity to appear before you today. I am prepared to respond to any questions you may have.

Mr. BENISHEK. Thank you.

Dr. O'Brien, please proceed.

STATEMENT OF CAROL O'BRIEN

Ms. O'BRIEN. Thank you for giving me the opportunity to discuss the Bay Pines VA Healthcare Systems' efforts to provide the very best care to our Nation's heroes, specifically those affected by military sexual trauma.

I will begin by providing a general overview of our health care system, the fourth busiest VA health care system in the country. The Bay Pines VA Healthcare System serves a 10-county area in southwest Florida, includes a large medical center located in Bay Pines and 8 outpatient clinics located in communities within our catchment area. Our health care system includes 3,500 employees who are dedicated to serving the more than 100,000 men and women who come through our doors every year.

I am the section chief of the health care system's post-traumatic stress disorder programs, which include residential and outpatient services to treat PTSD resulting from war-related trauma and from military sexual trauma. Our Center for Sexual Trauma Services is

the section of the PTSD programs that specifically treats PTSD resulting from sexual assault incurred during military service.

I began treating veterans with problems related to MST in 1993 shortly after the passage of Public Law 102-805. As a result of our experiences, a colleague and I requested and received a VHA innovative programs grant to establish the Bay Pines Residential Military Sexual Trauma Treatment Program in the year 2000. We initially had capacity for eight female veterans and subsequently expanded the program to treat an equal number of male veterans and to provide a wide range of outpatient services. At present, we treat approximately 100 veterans with military sexual trauma each year through our residential program, and our outpatient services provide care to approximately 400 veterans annually.

Our CSTS team provides evidence-based psychotherapy for PTSD as well as gender-specific treatment interventions and other therapeutic modalities to treat the unique aspects of MST-related PTSD. Because an overarching goal of treatment is community reintegration, our residential program has a strong focus on interpersonal skill development and recovery that is defined by the veteran's goals and values, and we incorporate concepts from therapeutic community models of care.

The Center for Sexual Trauma Services was the first MST-specific residential PTSD program to be established within VHA. In addition to providing excellent patient care for veterans who come to us from across the Nation, we initiated a national clinical training program in 2001, that has been attended by hundreds of MST clinicians from other VA facilities and from vet centers. In addition, our program has included ambitious clinical research initiatives since its inception and provides training for interns and residents from many disciplines.

Our residential treatment community includes equal numbers of men and women. Length of stay varies based on treatment needs and goals, and the patients take responsibility for the functioning of their residential community through mentoring and coaching each other, identifying shared community values and related behavioral goals, and focusing on independent problem-solving and management of difficult emotions.

We also focus on the gender-specific issues related to military sexual trauma. Our male and female patients meet separately to process the impact of military sexual trauma on important aspects of life, including sexuality, perceptions of others, and interpersonal relationships, and then come together to recognize that sexual assault affects both men and women and is not a problem of gender. Through their relationships with each other, they begin to trust again and they develop an eagerness to move forward with their lives.

As we continue to work to advance the understanding of the impact of MST and to develop increasingly effective treatment models, I respectfully make the following suggestions.

We have made huge progress in the availability of evidence-based treatments for PTSD, and these treatments have demonstrated efficacy for MST-related PTSD, but we need programs to specifically address the complex family problems, behavioral issues,

and co-occurring disorders that are typically seen in this group of veterans.

We need to provide treatment earlier. Most of our patients receive treatment years, and even decades after the sexual assault. Many of our veterans tell us that the MST resulted in the loss of their hoped-for military career.

VA and DoD need to prioritize effective early treatment interventions to preserve the quality of life and the potential contributions of military servicemembers who experience military sexual trauma.

We need more treatment options for men. We know that for men who are raped, the reporting rates are lower, the incidence of PTSD is higher, functioning in relationships and work roles is more impaired, and treatment is less effective.

Finally, we need to understand more about the causes and the predictors of military sexual trauma. We need additional VA-DoD collaborative research initiatives to understand the problem from the perspectives of both the victims and the perpetrators, so that we can design interventions relevant to the military environment to ameliorate this problem, so that there are no more victims.

Thank you again for the chance to testify.

Mr. BENISHEK. Thank you, Dr. O'Brien.

I will yield myself 5 minutes.

Dr. Shepherd, were you here for the testimony on the first—

Dr. SHEPHERD. Yes, sir.

Mr. BENISHEK. It was certainly dramatic testimony. You are with the Office of the Inspector General. Is the Inspector General's Office doing anything about this? Are they reviewing what the VA has been doing? It was pretty dramatic. I would think that you would have been on this in some way.

Dr. SHEPHERD. Well, as I mentioned in my statement, we did do a review in the last year of residential treatment for patients with MST-related conditions. We have done a review about 2 years ago looking at treatment for women with combat stress and—

Mr. BENISHEK. It doesn't sound like you are answering that you reviewed what the VA is doing with military sexual trauma in view of the testimony that we had before.

Dr. SHEPHERD. Yeah.

Mr. BENISHEK. Let me ask you this. Are you aware of the number of inpatient beds there are in the VA system for inpatient treatment of military sexual trauma, or that would have availability appropriate for MST victims, how many inpatient beds are there in the country?

Dr. SHEPHERD. I don't know the exact number.

Mr. BENISHEK. Do any of you know that number?

Let me ask you, the doctors that are involved with clinics themselves, are your clinics always full then?

Mr. FARRELL-HIGGINS. As I mentioned—thank you for the question, Mr. Chairperson—I mentioned in my remarks that we do experience some people who do not show up for treatment that is scheduled for them on our waiting-to-be-admitted list, but the advantage of us having a rolling admissions format as we do is that we are able to then pull people forward and fill those positions fairly quickly.

Mr. BENISHEK. How often does somebody have to typically wait? You mentioned that you have somebody waiting for admission—you have people scheduled for the fourth quarter, I thought you said.

Mr. FARRELL-HIGGINS. We do. Of course, we are in that territory. So we keep a waiting-to-be-admitted list so folks can get their personal affairs lined up and prepared to come into a program. It takes some doing to get family and work and so forth.

Mr. BENISHEK. How long does this typically take?

Mr. FARRELL-HIGGINS. So I would say that we are running about a month to 40 days right now.

Mr. BENISHEK. And so what is the census in your facility today?

Mr. FARRELL-HIGGINS. It varies.

Mr. BENISHEK. Today. Right.

Mr. FARRELL-HIGGINS. It runs from 80 to 95 percent.

Mr. BENISHEK. Dr. O'Brien.

Ms. O'BRIEN. Again, we typically run over 85 percent occupancy rate. The Bay Pines residential program is considered the premier program in the country. We get probably more referrals than other programs do. But a couple of weeks ago, we admitted a female veteran directly to our program from the inpatient psychiatry unit with absolutely no wait.

Mr. BENISHEK. We haven't heard from you, Ms. McGoff-Yost. Do you have anything you want to add to that?

Ms. MCGOFF-YOST. Yes. Thank you, Mr. Chairman.

As far as with our review, we looked at 14 different programs, VA facility programs, and we had to estimate the capacity because some of the programs are women's only and some of the programs are mixed gender.

For purposes of our review, we only looked at beds available for women with MST, and our estimated capacity was approximately 600. We did obtain data, both while we were on our site visits, and also, we looked at VA self-reported data that had to do with the capacity, and we were consistently told while we were on site, that these programs were somewhat underutilized.

The time period for which we did our review was the first two quarters of fiscal year 2012, which would be October 1st, 2011, through March 31st, 2012, and during that timeframe, the data provided by VHA's Northeast Program Evaluation Center for these particular programs reflected an occupancy rate ranging from 42 percent through 81 percent. The programs that had a higher occupancy rate included Bay Pines, Lyons, New Jersey, and Sheridan, Wyoming.

As far as your questions about how long it takes to access the programs, we can get you that information. We reviewed 166 medical records as part of our review, and within our report, we do have the data stratified by facility of how long it took from the time that a patient was referred to the program until the patient entered one of the residential programs, and it did vary considerably.

Mr. BENISHEK. Do you think that the IG going to, in view of the testimony we had today, do you think you would entertain a plan to try to inspect how VA is doing things? With the dramatic testimony of coordinators, shouldn't the Inspector General be involved in that?

Dr. SHEPHERD. I very much appreciate the testimony, and when I return today to the office, I will begin dialogue with my superiors about possible inspections we might do in this area.

Mr. BENISHEK. I would appreciate follow-up to the Committee. Thank you.

Ms. MCGOFF-YOST. It is something that has been discussed. When we—he initially looked at doing this review, we chose to look at the residential programs. Because these programs were identified by VHA as being specialized treatment resources specific for this population, one of the things we did consider was looking at outpatient services, which is a little bit more challenging because it is so broad. Because every facility is required to offer MST-related care at every facility at every CBOC, it was a challenge to figure out to objectively measure what they were doing, and there can be so much variability from site to site.

Mr. BENISHEK. Right.

Ms. MCGOFF-YOST. One of the things that we considered, currently VHA facilities have a screening program where they are supposed to be doing a screening. It is an electronic screening called a clinical reminder, where it is once in a lifetime, they screen a veteran for the presence of military sexual trauma. Currently, the clinical reminder consists of two questions to just determine if a patient met a criteria, at which point they are supposed to be verbally prompted to see if they would like to talk to someone further.

We were told that VHA is in the process of adding a third question to the reminder that would actually document whether or not the person would like to seek help or further assistance related to a positive screen. One of the things that we have discussed is that once the clinical reminder is in place, there would actually be an objective way for us to measure how many veterans requested help. Then we could go back and see how many got the help they asked for and how long it took.

So we are kind of keeping an eyeball to see when that reminder might be getting ruled out. We were told during fiscal year 2012 that it was under process. As far as we know today, it has not yet been rolled out nationally.

Mr. BENISHEK. Thank you for your testimony.

I yield to Ms. Brownley.

Ms. BROWNLEY. Thank you, Mr. Chairman.

And thank you all for your testimony.

You know, hearing the first panel for me was disconcerting, devastating, and your response to the testimony, it didn't seem to me that that sense of urgency really is there. I mean, we heard about big gaps in care, long wait times, uncaring providers, employees that didn't seem to know what the policies were, issues around family support, gender-sensitive care, the fact that PTSD and MST therapies were combined, the need to get access outside of the VA, victims not being screened.

And the data that we know, in terms of the victims who are out there and the victims, 87 percent, I think, who actually were victimized but don't come forward, it just doesn't seem that—your testimony and the data that we know about are really, you know, aligned here, and somehow, I think we have got to, you know, find those nexus points so that we are doing, you know, a better job.

So I feel like this hearing is just beginning to scratch the surface, and we still need to drill down further on so many of these issues to figure out how we can provide immediate service, caring service, the right services, the best practices, and I am sort of struggling with that.

I appreciate your testimony. I feel like it was, you know, prepared in advance, which I understand one has to do, but it didn't feel as though it was really responding to what we heard.

So I would just like to hear from you, from all of you, really, what some of your responses are. And I know in the case of Mr. Lewis, who testified, and, Dr. O'Brien, you know, he gets services from your facility and, you know, if we could hear a little bit more from you about some of his testimony and some of his experiences.

Ms. O'BRIEN. Thank you. And I, like you, reacted with a great deal of concern and compassion for the testimony of not only the male victim, but the entire panel. And as we move forward with this, a part of what we need to do within VA, is to talk with our veterans, to listen to those concerns, to continue to work with them in order to improve our programs to meet every single individual veteran's needs.

One of the things that we are doing right now in VA that I think will be especially helpful is that we are hiring a large number of peer technicians, peer counselors to work with our programs, and we will have one coming to our program at Bay Pines as well. And again, that allows us to hear the veteran's perspective. And I think the closer we get to the words of the veteran, the more we will be able to improve and continue to improve our treatment programs.

Ms. BROWNLEY. Any other comments?

Ms. MCGOFF-YOST. I actually have a comment, Ranking Member Brownley. When we did our review, we looked specifically at women, at the request of the Senate VA Committee, and we looked specifically at specialized inpatient and residential treatment programs. So in a manner of speaking, we have a skewed sample, because we looked at those patients who made it into a very specialized program, whereas I think that the veterans in the first panel who spoke so openly and courageously about their experiences, from what we could gather from their testimony it sounded like only one of the four made it into one of these specialized programs. So while we can discuss the characteristics and the patterns from what we saw in our sample of women in our view, it may not be reflective of the women who aren't making it into these residential treatment programs.

We did find evidence, both in the medical records, and also through interviews and site visits, we did hear about barriers, and many of the barriers that we heard from staff were very similar themes to what we heard from the veterans who spoke earlier today. We consistently heard that the MST coordinators, there is one at each facility, that is what we found in our review, that is what is required, however, the directive that mandates this role to exist does not mandate the amount of FTE or time dedicated to the role that it needs to have.

We were consistently told on-site that—most coordinators said that they are mapped at about 10 percent of their time to doing MST coordination. For instance, at the Bay Pines facility, their

MST coordinator is a very busy lady, she wears many hats. She is a full-time clinician, she works with patients in the residential program, she is the MST coordinator, and she is also the VISN point of contact for MST, and that is one person.

So we were told by most of them it is 10 percent. A few said it was as few as two hours a week they are afforded to do the outreach that they need to do. And I think that when you listen to the examples we heard from the prior panel, a lot of them echoed that, had there been a lot more outreach and a lot more focusing up front on coordination and reaching out to patients when they are coming into the system, that perhaps could have ameliorated some of the issues related to their coordination of care.

Ms. BROWNLEY. Thank you. I yield back.

Mr. BENISHEK. Thank you, Ms. Brownley.

I yield 5 minutes to Dr. Wenstrup.

Mr. WENSTRUP. Thank you, Mr. Chairman. Thank you all for being here today.

I know it is difficult, but always necessary in everything that we do to self-critique ourselves, and I just wonder how you would describe or rate, on a national level, your customer service as far as those with MST and what is it that you need that is not provided to you today to improve upon that? Anyone can take that.

Mr. FARRELL-HIGGINS. Thank you for the question, Congressman. I believe in Topeka, our customer service is outstanding. We have an excellent team, and the feedback that we get repeatedly, both from veterans who have come through the program, especially from our referral services as well, is that they are very pleased with the care that they have received from us.

I think we can always do better. We have brought on a peer support specialist this past year to help us out. I think it has been a very strong move for us. We are continuing to look at how we can link in better with local community resources to help become more linked in with things such as recreational activities. Some staff dollars would help with that, but I think we can do some improvement there.

Mr. WENSTRUP. Thank you.

Anyone else care to comment?

Ms. MCGOFF-YOST. I have a comment, since both of the panelists from VHA mentioned the peer technicians and peer counseling is such a positive recovery movement that is being rolled out in VHA. That is something that we noticed when we looked at the medical records for these women with MST who are in a residential program. We did find the presence in many of the programs we looked at, that there was peer counseling available or a peer support technician who was there. However, from what we could see in the medical record documentation, and we were looking at veterans who were women, we only saw one female peer support technician who was working in these particular programs, and I believe that was in the program in Cincinnati. And I know that VA has mandated that the residential programs need to get ready to have up to 15 percent of their population be female. However, they have no set threshold for what number of their peer support technicians need to be female.

Mr. WENSTRUP. Thank you very much. And I yield back.

Mr. BENISHEK. Ms. Kuster, 5 minutes.

Ms. KUSTER. Thank you very much, Mr. Chairman. I will be more mindful of my time. Thank you.

Thank you so much for coming before us today and for the work that you do. I understand that you are very committed to it. And, Dr. O'Brien, I admire you being a part of this for a long, long time.

And, Dr. Farrell-Higgins, I am impressed by the program you described. And thank you to our friends that are looking into this deeper.

So my question, I want to focus in on a comment that you made, Ms. McGoff-Yost, about—you used a phrase “once in a lifetime screening,” and I guess the comment that I would have is, it is very clear to me from our first panel that once in a lifetime screening would not be adequate. And I think actually Dr. Roe spoke very eloquently about this, of knowing his patients for 30 years and it takes 25 years to have this conversation.

So what would you recommend that could be done across the board throughout the VA to be more mindful of the challenge of bringing this situation forward, that it is not just saying, I broke my arm, can you fix it?

Ms. MCGOFF-YOST. I think that part of this issue has to do with the MST coordinators and the time that they are afforded to follow up on screenings, and also when they are working with—when a patient does disclose in whatever venue it is, to make sure that the coordinator is aware and that the screening then gets put back to being positive in the medical record.

A clinical reminder, they can be set in the electronic medical record at certain intervals. We were told by VHA that currently this is something that occurs once. When a person, male or female veteran, comes into a VA medical center for enrollment, they are screened for many different conditions. MST is one of them. There are two questions in the screening, and as I mentioned earlier, we were told they are in the process of adding a third question.

We would probably need to defer to VHA for more specific information about their future plans for the clinical reminder. We did have some dialogue with VHA staff at central office about the clinical reminder and the pros and cons of having it come up more often than annually.

We did find in our particular sample all of the veterans had been screened. We did find that out of our 166 patients, 161 were actually veterans, three were active duty, and two were reservists. So of the 161 for whom the clinical reminder would have been turned on in the medical record, for seven, it was still marked negative. And that has an impact on VA collecting data because they make tremendous efforts to collect data on these patients. If the clinical reminder is marked negative, then some of the data that they collect would be lost.

Ms. O'BRIEN. Could I add also that, although in VA we have the requirement to ask once to do the reminder, that is not the only way that we reach out to our veterans to let them know about the availability of treatment and so on. We have brochures, we have posters, we have events for Sexual Assault Awareness Week. In multiple modalities we reach out to our veterans to let them know that the care is available and to encourage them to seek care.

I had a veteran say to me the other day that he had said no to the clinical reminder, and then he saw a poster at our facility that we have hanging right inside the door that says it takes the strength of a warrior to seek help, and that gave him the courage to come to us and say, I was sexually assaulted in the military and I hear I can get some care from you.

Ms. KUSTER. Great. My time is short, but I do want to take the opportunity to introduce an expert from my region in New Hampshire who is here with us today at the hearing, Victoria Banyard, Ph.D., from the University New Hampshire.

Ms. KUSTER. But with regard to your comment, Dr. Farrell-Higgins, I think the connection to the services that are available in the community, including in academia, in programming, the issue of sexual assault and rape is not new in our society. And one of my biggest concerns across the board, both with regard to DoD and the VA, is that there is this effect of a total vacuum of the military and the Veterans Administration seemingly dealing with these issues in a vacuum.

And so, I would encourage all of you, and certainly we will encourage the Veterans Administration and the DoD, to work with the civilian population, because it is very unique, both with regard to coming forward and telling the story and all the way throughout. And so, our concern is with this multiple trauma, that we learn best practices from people who have worked. Dr. Banyard has been working for 20 years in this field, and I am very honored to have her with us here today.

Thank you. And I yield back.

Mr. BENISHEK. Thank you very much.

I will yield 5 minutes to the gentlewoman from Indiana, Ms. Walorski.

Mrs. WALORSKI. Thank you, Mr. Chairman.

And I have to agree with Ranking Member Brownley in sharing her frustration. I feel like we are in two separate worlds. We just heard absolutely gut-wrenching testimony from extremely courageous people whose lives have been ruined, and I am frustrated sitting on this Committee.

I have been asking questions about this issue to the VA since I have been here with no answers. So with all due respect, Dr. Higgins, the customer service is going great? Well, maybe for those who actually access the program. But to the people that are sitting here representing tens of thousands of people, it isn't working and I am just frustrated.

But I want to direct my attention to Dr. Shepherd. In the report produced by the Office of the Inspector General, it is recommended that, quote, "The Under Secretary for Health review existing VHA policy pertaining to authorization of travel for veterans seeking MST-related treatment as specialized inpatient residential programs outside of the facilities where they are enrolled. The VHA agreed with this recommendation and promised to have a recommendation completed for the Under Secretary for Health no later than April 30, 2013." Has the VHA provided you with that status update?

Dr. SHEPHERD. A quarterly update, which was in May, they were still working on it and haven't come up with a list of recommendations.

Mrs. WALORSKI. And let me just interject. That is exactly what I expected to hear, because the questions that we have been asking in the 7 months that I have been here still fall on deaf ears; no response, no report. When we are dealing with this issue of MST, the reason these stories are so gut wrenching, I think, is because we have thousands of people falling through a crack in the system and we can't even get answers to the Congressional Committee that is in charge of watchdogging and making sure that these people get treatment.

Dr. SHEPHERD. In fact, in the last few days, with a lot of pressing, we got a response that they recently had developed some recommendations that the Under Secretary would be reviewing in the last few weeks. So I agree with the congresswoman's comments and I very much understand the frustration.

Mrs. WALORSKI. Did the VHA give any reason for failing to fulfill their promise?

Dr. SHEPHERD. No, ma'am.

Mrs. WALORSKI. Does their failure to address the situation demonstrate their inability to provide the necessary services to MST victims, in your estimation?

Dr. SHEPHERD. It is hard to say. Certainly we would like to see a prompt response to the recommendation we had, and we would like to see what they have recently proposed get implemented, because we think that will help improve access for veterans needing these programs.

Mrs. WALORSKI. Thank you.

And, Mr. Chairman, I yield back my time.

Mr. BENISHEK. Ms. Kirkpatrick.

Mrs. KIRKPATRICK. Thank you, Mr. Chairman.

Dr. O'Brien, how many of the 3,500 employees at your facility are psychiatrists?

Ms. O'BRIEN. Thank you for the question. I would need to take that for the record and get back to you on the exact number.

Mrs. KIRKPATRICK. Can you give me a ballpark number?

Ms. O'BRIEN. I can tell you that in our PTSD program itself, we have two psychiatric ARNPs and two full-time psychiatrists, with a position open for yet another psychiatrist.

Mrs. KIRKPATRICK. I don't have your written testimony, but I am recalling from your testimony that you said you treat 100,000 inpatients at the facility and 400,000 outpatients, is that correct?

Ms. O'BRIEN. I indicated that we have 100,000 male and female veterans who come to our facility each year.

Mrs. KIRKPATRICK. And how many of them are seeking mental health care?

Ms. O'BRIEN. Again, I don't know the exact number. I can get that information to you.

Mrs. KIRKPATRICK. I would appreciate that.

Dr. Higgins, can you answer those questions for me for your facility?

Mr. FARRELL-HIGGINS. Thank you for the question. I find myself in a similar situation as Dr. O'Brien. On the inpatient PTSD unit,

we have a full-time PA and an ARNP, with a psychiatrist who supervises that work. I will have to get back to you with respect to the total number of psychiatrists in the facility.

Mrs. KIRKPATRICK. Can you give me a ballpark?

Mr. FARRELL-HIGGINS. Let me get back to you about that.

Mrs. KIRKPATRICK. Okay.

Mrs. KIRKPATRICK. Ms. Yost, you talked a little bit about staffing in a previous question. Do you think we have a sufficient number of psychiatrists in the VA system to treat these issues?

Ms. MCGOFF-YOST. Under our review, we looked at the staffing specifically of particular residential programs, so I would not be able to comment on the adequacy of staffing for the other 140 VA facilities as far as the availability of outpatient services. We found that there was adequate staffing for the particular programs that we reviewed which were residential inpatient in nature.

Mrs. KIRKPATRICK. I am really concerned about the testimony we heard from the first panel, that they are being seen by medical students, by untrained professionals, and really would like an answer back about whether or not we have adequate professionals within the VA system to deal with military sexual trauma.

Mrs. KIRKPATRICK. Also, in the written testimony of one of the first panelists, she says some women are not going to come to the VA because of a lack of treatment or a bad experience with the VA, and we have heard in other hearings about women being hesitant to go to the VA. And I would just like to know from the panel, what efforts the VA is taking right now to address that, to make it a pleasant experience for women, someplace where they would feel protected and welcome.

Ms. O'BRIEN. Thank you. I think one of the things that VA has done over the years is the creation of women's health centers. Every VA facility has a women veterans program manager whose job it is to advocate for women veterans throughout the facility. And I will talk about the Bay Pines women's clinic. It is a separate clinic dedicated to the health care of women veterans, and in that clinic there are also mental health providers. So that if a woman veteran comes to ours facility and feels uncomfortable getting care in a general mental health clinic or another setting, they can get virtually all of their care in the women's clinic.

Mrs. KIRKPATRICK. Dr. Shepherd, are you aware of anything that is going on within the VA to make it user friendly for women?

Dr. SHEPHERD. I think ideally that is a question answered by the two panelists from VA. But I can say, going back 4 or 5 years ago, in these residential programs, there was really concern about physical safety, or that, that was more of an issue, and many of the programs did put, you know, like keypad or other type devices to try to bolster security. I can offer that, but I really think that is probably best answered by the VA panelists.

Mrs. KIRKPATRICK. Ms. Yost, do you have any comment on that, maybe some ideas about what could be done better?

Ms. MCGOFF-YOST. Just to echo the sentiments of Dr. Shepherd. Our Office of Healthcare Inspections, when they do scheduled site visits, called CAPS, at approximately 50 VA medical centers each year, they are looking at the safety and security of the mental health residential treatment programs. They found very high com-

pliance with the standards pertaining to the safety and security for women veterans in those venues as far as required alarms, door locks, rooms and bathrooms being able to lock, CCTV at building entrances and whatnot.

I do know that the OIG is looking—always has a component relevant to women’s health, typically in our scheduled site visits both for medical facilities and on our CBOC reviews, so it is something they are keeping an eye on. I cannot personally comment on the adequacy of their efforts overall as far as being more welcoming to women.

Mrs. KIRKPATRICK. Dr. Higgins, can you describe what is going on in your facility with that regard?

Mr. FARRELL-HIGGINS. I would be happy to. We also have a women’s health clinic where a full comprehensive range of services is available. With respect to our unit, we do indeed have alarms on doors, and doors can be locked at night and so forth, so to maintain the physical security of those rooms.

I think that the message is best delivered every time we interact with a female who comes into the VA, it is that individual contact that makes the difference. And our staff, I know staff on my end, is well-trained and committed to that, because we do understand the gravity of the stories that are going to unfold before us as we work with these women and men who have been sexually traumatized.

Mrs. KIRKPATRICK. Thank you.

And, Mr. Chairman, thank you for indulging me to exceed my time. Thank you.

Mr. BENISHEK. Thank you very much, Ms. Kirkpatrick.

I would like to yield a couple more minutes to the Ranking Member, Ms. Brownley from California. She has an inquiry.

Ms. BROWNLEY. Thank you, Mr. Chairman. This inquiry is really to the Office of the Inspector General, Dr. Shepherd.

We have heard today, in today’s testimony, a lot, but one area that I wanted to focus on is the transition area from DoD to the VA for military sexual assault victims. So I know, my understanding anyway, that back in 2009 there was a DoD-VA mental health summit, and from that summit, there was, I think, an agreed-upon strategy coming out from the DoD and the VA, but we really don’t know anything about it and really what has happened with that. We don’t know what the strategy is, et cetera.

So I think, and I think the Chairman agrees with me, that I would certainly like the Inspector General to look into this issue around transition, and how the DoD and the VA are going to work together to service our military men and women who have been sexually assaulted and report back to us in the official capacity out of the Office of Inspector General, and would like that to happen and to have a report that would come back to us.

Dr. SHEPHERD. In light of all the heartfelt concerns expressed and shared by the first panel, I personally would be honored to work on that.

Ms. BROWNLEY. Thank you, sir.

Mr. BENISHEK. I would like to thank all of you very much for coming to testify before us today, and you are hereby excused from the panel.

I would like to call up the third panel. We have from the Department of Veterans Affairs Dr. Rajiv Jain, VA's Assistant Deputy Under Secretary for Patient Care Services. Dr. Jain is accompanied by Dr. David Carroll, the Acting Chief Consultant for Mental Health Services for the Office of Patient Care Services, and Dr. Stacey Pollack, the National Mental Health Director of Program Policy Implementation for the Mental Health Services of the Office of Patient Care Services. That is a long title. We are also joined by Dr. Karen Guice, who is the Principal Deputy Under Secretary for Defense for Health Affairs.

I want to thank you all for being here today. We have your complete written statements as part of our hearing record.

Mr. BENISHEK. And given the gravity of the testimony and personal experiences that we have heard in the previous panel, I would like to go straight to questions, if you don't mind.

You were all here for the testimony of the first panel, I take it. To me, it is very, very frustrating to hear that, and to know there are many out there that we haven't heard today, that have the same complaints. And I know that I have received constituent letters about how people have been sexually assaulted in the Vietnam war, but still haven't reported it to their VA contact because they are just afraid. And they didn't reveal it until they wrote me the letter. This testimony is just so devastating.

I know you have a statement there, but maybe, Dr. Jain, you can tell me, what was your reaction to the earlier testimony, and what do you think that the first thing you are going to do after this hearing to try to fix this is going to be?

Dr. JAIN. Thank you, Mr. Chairman, for the question. I think there is no question that our testimony that we submitted, as you said, is already somewhat dated based on the testimonies that have been provided by the four veterans on the first panel. I think they really present a very powerful story, and I think that they point out that inasmuch as we in the VA have done a lot for survivors of MST over the last few years, we also feel that there are significant gaps that have been pointed out by the panel that we need to really look, careful look and address and see how best we can meet the needs of all of our veterans in a sensitive manner.

Mr. BENISHEK. Wouldn't you agree that this is an emergency, that there should be rapid action taken?

Dr. JAIN. Yes, sir, I would agree, and we would certainly go back and take a very critical look at how we have structured services and what can we do to address some of the gaps. And, frankly, they made a lot of wonderful suggestions that we also would want to consider.

Mr. BENISHEK. Do you know who would be in charge of that? Is there someone in charge of this VA? I get confused with the principal deputy, assistant director, those type of terms. I get confused. So is there someone that you can name that is in charge of fixing this?

Dr. JAIN. Well, sir—

Mr. BENISHEK. Is that you?

Dr. JAIN. That is in charge of the patient care services? I would certainly be willing to take that responsibility on the behalf of the VHA, because all of the mental health services and the MST serv-

ices are part of the mental health services and patient care services. So I would certainly be personally willing to take that responsibility to do a careful assessment, working with our leadership on the operations side, to make sure that we have all of the appropriate—the staffing that we need to make sure that we provide the services in a sensitive manner.

Mr. BENISHEK. Well, you have to have some caveats in there, I understand, Dr. Jain. But to tell you the truth, I really appreciate your answer, the fact you are willing to sit there. And I worked at the VA as a consultant for 20 years, and I know sometimes a straightforward answer that you gave doesn't happen that often, even with the caveat.

I will yield the remainder of my time and allow Ms. Brownley to go on.

Ms. BROWNLEY. Thank you, Mr. Chair, and I certainly share your sense of urgency here today.

Earlier in the hearing, there was some discussion about the chain of command, and I think certainly this issue, we need to go up the chain of command within the VA and within the DoD to make sure that we are addressing some of these issues, and that we are really providing the very best practices to our men and women who have served us so bravely and have so bravely testified in today's hearing.

I wanted to go back to some of the specifics from panel one that were suggestions, and one is going outside of the VA for services, to access services that may be closer to home, to access perhaps services that are best practices if it does not exist within the VA. And it seems to me that if we do have these gaps in care and so forth, and we want to address this with that sense of urgency, that perhaps one solution could be is to look at the utilization of outside services for our men and women within their areas of which they reside. It seems to me, if those best practices are out there and being provided, that this may be a way in which to provide those services in a very efficient and expeditious way. And just wanted to hear any comments from you with that.

Dr. JAIN. Thank you, Congresswoman, for that question. Let me start the discussion on that particular topic. I think, as you say, our VA medical center leadership at all of the facilities have a range of options available to them in terms of looking at how to provide services in a timely manner. And clearly the veterans on the panel have pointed out that fee basis care is one of the options.

I would also submit to you that we have telehealth services, and I think that was pointed out, that we could have these clinics. As you know, we have lots of community-based outpatient clinics. Over the last several years, mental health has now become a component of the primary care services that are provided at our CBOCs.

What we have done over the last few years is, we have added the telemental health services to further expand the reach of the experts that we have at the medical centers, to make sure that higher level of expert services is available in our clinics.

But listening to the testimony of one of the veterans, it is clear that there are some areas of gaps. There are some areas where perhaps the veteran was not able to reach a community-based outpatient clinic, where there was also a combination of mental health

services and other types of expert services for survivors of MST that may be available.

The issue of fee based services is certainly there and clearly, as you say, is one of the options. The challenge that one faces, though immediately, is that you have to look at whether there are the right professionals available to make sure that service is available in a timely manner. I think the veterans pointed out the challenge of the exchange of medical record information. When the services are provided within the VA or when we partner with HRSA, for example, or when we partner with Indian Health Services, you know, we have done several projects now where the VA in partnership is working with those types of agencies to make sure that we share resources and we provide the care in a timely manner to where the veterans are.

So I think there is a range of options, and clearly one of the options would have to be fee based services. But let me ask Dr. Carroll if he would like to add anything.

Ms. BROWNLEY. Well, I would like to go on further with another question, if you don't mind.

Dr. JAIN. Sure. Please.

Ms. BROWNLEY. The other issue is around screening, and to me that seems like that can just be a simple fix, to make sure across the country that we are doing the screening. And it was very concerning to hear Ms. Johnson, who is our most recent servicemember and veteran, who clearly was not screened. And so we say we are screening, but yet I think from the testimony, we can conclude that it is not a fail-safe program, that every single man and woman are not being screened. It is something that is not complicated, it is just a matter of making sure that we are doing it.

I also think vis-&-vis screening that screening is something that it is not just a one-time thing. We have to continue to sort of follow up, and there probably needs to be other places in the process where they are screened again so it is not a one-time thing, so that it is more of a check and balance and more of a fail-safe system.

The other thing that has come to mind in listening to the first panel is having advocates for these men and women that can access the system, to prioritize their needs within the system to get the services that they need and when they need it, and can help in the coordination, also in making sure that from every place, wherever it may be, that they are getting what they need.

And just would ask if you could comment on any of those.

Dr. JAIN. So, Congresswoman, thank you very much for those comments. And I fully agree with you, I think that there are many points that our veterans made, in terms of suggestions, that we would take to heart, and we will go back and review our current policies and procedures to strengthen.

For example, screening, as you point out, I think there are some things that we would need to look. I was very surprised to see that none of the four veterans. Now, in some ways the possible explanation could be that maybe the screening was conducted a few years earlier when the screening was not fully in place, but that is still not a reason not to do that again.

I think you point out a very good thing here, and I think the veterans have indicated that we need to look at our procedures for screening, to see if there is a way we could offer some kind of another chance to have the screening done in a simpler way. So I would fully agree with that.

I think your other point also makes sense in terms of veterans having options available, i.e., some kind of a coach or a coordinator, and I think we are toying with some of those ideas in our primary care clinic, in our PACT Program. We have recently introduced the concept of coaches or health coaches, and these are over and above the OEF/OIF coordinators we have. As you know, the OEF/OIF coordinators help in the transition of the servicemembers coming into our system, but they also assist in coordinating care, whether it is coordination with other specialty clinics, or coordination between the VA and the community. You know, a lot of our PACT teams have these post-deployment counselors that also sort of provide a similar kind of a role.

But I think that what we are beginning to do now is to add some more coaches that can help to further strengthen this element of coordination of services because of a lot of the dual care that happens in our system.

Ms. BROWNLEY. Thank you. And if the chair would allow me a little bit more time, I would like to just ask the DoD to respond to some of these issues as well.

Dr. GUICE. I think there is a lot that we have done recently. We have a new DODI instruction which kind of talks about the roles and responsibilities of everyone in the Department of Defense to specifically address sexual assault, prevention, and response. That was just issued in April. The services are in the process of fully implementing it. We know they are compliant with the health care provisions in there. So we know that providers are trained, we know that they are meeting the standard for providing 24/7 coverage, that there are SAFE kits in all of the MTFs.

So I think we have actually responded in a thoughtful way to what we also heard from survivors in our focus groups in the Department of Defense to kind of fix some of the problems that were articulated. We are just kind of seeing if we have solved some of the problems certainly that were articulated for the health care parts of it. I know we still have some outstanding issues with regards to some of the other things that you all have articulated here.

But I just want to articulate my thanks to the first panel. It is only through their eyes that we actually see us as we are, and that is how we fix things. So I am very grateful to their willingness to come forward today and help us and see things the way they see it. That is only how we get better.

Ms. BROWNLEY. Well, thank you. Thank you for that. I think we all walk away today, hopefully the Congress, DoD, and the VA, walk away with a sense of urgency today that we have a lot of work ahead of us.

Thank you, Mr. Chair. I yield back.

Mr. BENISHEK. Ms. Kirkpatrick.

Mrs. KIRKPATRICK. Our Committee has heard that a stigma exists in the military that deters active servicemembers from getting

mental health care. One of our veteran panelists suggests that there be a Mental Health Day where professionals are brought together so that servicemembers can seek mental health care that day and actually see professionals. Dr. Guice, has that recommendation been explored before?

Dr. GUICE. I have actually not heard of that particular recommendation. We have done a lot in the past several years to provide embedded mental health providers, both in the deployed environment, we have embedded behavioral health specialists in our primary care teams for the patient-centered medical home. So I think we are doing a pretty good job of trying to penetrate and provide our behavioral health specialists where they need to be, and so that they are not seen as something different, but they are just part of your group. And I think that that is going to go a long way.

We actually have seen in the Department an increase in people accessing services for mental health, which I think is a good news story. That, I think, means that we are addressing stigma. Have we totally fixed it? Probably not. But I think some of the maneuvers and some of the choices that we have made are actually making some inroads into it. So I am quite positive.

But I will take back the idea of a Mental Health Day and we will see how people respond to that.

Mrs. KIRKPATRICK. I represent a very large rural district in Arizona, and we are using more and more telemedicine. And I am finding that patients are very open to that and find it is a very positive experience. I am just thinking that telemedicine may be a way for some of our veterans to seek mental health treatment in the privacy of their home without having to go to a facility.

Dr. Jain, would you address that idea?

Dr. JAIN. Thank you, Congresswoman, for that question. I think the potential for telehealth is still, I would say, in its infancy, so we really can take this to many different levels. I think the point that you are making and the veterans have made, providing care where the veterans live in that community, I think is a message that we have taken to heart. And we have done a lot, but we need to do a lot more.

I think that the days of asking the veterans to drive 200 miles or 150 miles to come to the mother ship and be able to receive care, I think has to be a passe, and we need to move on to the point where we are able to provide more services either in our community-based outpatient clinics or potentially in their homes.

So, yes, that is certainly an area that we are looking at very actively, and we will continue to expand that.

Mrs. KIRKPATRICK. Thank you. And again thank the panelists for being here today. And I yield back.

Mr. BENISHEK. I am going to ask just a couple more closing questions.

Dr. Guice, looking at this GAO report from January of this year, it says we found that military health care providers do not have a consistent understanding of their responsibilities in care of sexual assault victims.

Did the testimony of the first panel, did that affect you in your thoughts of how things are going in the system?

Dr. GUICE. I think the testimony of the first panel was compelling and heartwrenching. I think that the things that we have addressed in our new guidance to the field, though, will go a long way to actually try to remedy some of the things that they articulated.

All health care providers who come in contact who have any kind of role or responsibility for sexual assault and treating those patients are required—required—to have an initial treatment and an annual refresher course. Those that actually perform the SAFE exam, which is the forensic examination, are required to have very specific training to a national standard, which is the Department of Justice.

Mr. BENISHEK. Let me just ask you one quick, short question here. There has been some concern about people who have survived MST and their inability to stay on active duty because there is maybe not quite the treatment protocol to allow them to do that. Is there some way that we are addressing that in the DoD?

Dr. GUICE. I would have to actually go back and talk to people about that just to make sure that we have got something in place that is directly addressing that particular question, sir.

Mr. BENISHEK. All right. I would appreciate getting back to me about that.

Mr. BENISHEK. I want to thank you all for joining us this afternoon. I truly appreciate it. And I hope that, as I said earlier, that the testimony of the first panel affects you all in your zeal to make things better from every aspect of VA and DoD, because I know it is certainly affecting us here on the Committee, and we are going to work on improving it from our end. But I would hope that this would inspire you to work harder in making it happen.

So with that, you are excused. Thank you.

[THE PREPARED STATEMENT OF RAJIV JAIN, M.D. APPEARS IN THE APPENDIX]

[THE PREPARED STATEMENT OF KAREN S. GUICE, M.D. APPEARS IN THE APPENDIX]

Mr. BENISHEK. I will ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material.

Without objection, so ordered.

Mr. BENISHEK. I would like to once again thank all of the witnesses and the audience members for joining us here today for these important conversations. And this hearing is hereby adjourned.

[Whereupon, at 1:45 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Julia Brownley

Good morning. I would like to thank everyone for attending today's hearing, focused on examining the care and treatment available to survivors of military sexual trauma. The Subcommittee will also be looking at the coordination of care and services offered to the victims of MST through the Department of Veterans Affairs and the Department of Defense.

Many MST victims who have suffered through an ordeal such as sexual assault often times are reluctant to discuss their situation and seek help. Those that finally gather the courage to speak up find that their story is often dismissed or treated indifferently, unjustly becoming the victim again.

As many of you know, the Pentagon reported earlier this year that an estimated 26,000 cases of unwanted sexual contact occurred in 2012, up from 19,000 in 2011. With only 13.5 percent of incidents reported, it is clear that we must do a better job in both preventing and treating MST. These servicemembers and veterans often continue to experience debilitating physical and mental symptoms from MST, which can follow them throughout their lives.

Focusing on prevention, however, is only part of the solution. It is critical that we do all that we can to make it easier for victims of MST to access needed benefits and services and receive treatment. Compassion and care are a significant part of healing those that have been sexually assaulted.

I applaud the legislative efforts of our colleagues who have introduced legislation, H.R. 1593, the Sexual Assault Training Oversight and Prevention Act and H.R. 671, the Ruth Moore Act. These bills seek to ensure stronger protections are in place so that the safety and well being of our men and women in uniform is assured. We must begin to take these important steps to end sexual assault. As a proud cosponsor of both bills, I believe we are headed in the right direction.

I was saddened to read the testimonies of our first panel. The pain and suffering was evident in the personal stories written. I know that this is hard for all of you and I commend you on your bravery to speak up today. We need to hear, firsthand, the experiences of veterans who have found the system unfriendly and intimidating so that we can make it better.

I look forward to hearing from our witnesses today. Thank you, Mr. Chairman, and I now yield back.

Prepared Statement of Victoria Sanders

I paid a big price to be asked to be here today. I belong to an exclusive club. The kind no one wants to be a lifetime member of, vacations are permitted but PTSD will always be there. Each step along the way we have lost good people. Some have died at the hands of their rapist before they could ever report anything. Sophie Champoux died while on active duty of a gunshot wound to the head. She was raped two times by the same man. He confessed went to Leavenworth was to be released very near the time that Sophie's headstone was delivered. Carri Goodwin died 5 days after being discharged. A combination of medication, given to her by the military before discharge, and alcohol killed her. I attempted suicide in 1985 just 10 years after my rape. I was lucky that attempt failed.

It took almost 20 more years of slowly increasing symptoms until a woman was raped 15 feet from my front door and my life came close to ending again. In 2004 I talked to my mother and told her for the first time about the rape in 1975. I had never told anyone. If they would have given me the survey about sexual assaults in the military I would have said I was not sexually assaulted. The guilt, shame, and self-blame would not allow me to see what I now understand more clearly. My symptoms are still bad. The nurse training I got with my G.I. Bill helped me to be

able to put on a brave face and go out to the world. The woman who inspired me to become a nurse worked at the VA and on bad days she might say "I could make a lot more money someplace else but those boys need me." This was in the late 60's early 70's the height of the Vietnam War. I expect the same from my care givers.

I was lucky at Palo Alto I had people who did things for me to keep me going. The first appointment I got was with a PhD who stayed after hours to see me. The woman at the vet center did me the favor to call the PhD. I was lucky. No matter how hard it is for me I know how lucky I am. I can ask for what I need. I know how to handle the symptoms but can't always keep them under control. I was raised by a single mother with no high school diploma. As I tell people I was born in Georgia and we were dirt poor. We moved to Kansas and we could not even afford dirt. I am lucky that my mother told me to go to the VA, lucky that the first person I saw asked the right question. Tell me about your time in service. Everything fell out of my mouth. The rape, the harassment, the custody battle, years of denial all came to an end that day.

Again I was lucky after my fiance Alan Seidler died his family cared enough about me to give me money every month. Homelessness was not an issue. At a certain point I was afraid to be alone so I moved in with family friend. Dr Betty Mudock was an 80 year old woman who had Alzheimer's. I needed her she needed me.

When Dr Irene Trowell Harris came to Palo Alto with a large group of Washington people I told her I was lucky that I got the care I needed when I needed. That I was able to verbalize what other can't. That a part of me can, as I am doing today, put on the suit of armor and go on through the battle. Later I will lick my battle wounds and revert to isolation, fear, anxiety, flashbacks, anger, not being able to open my mail. Not being able to be the mother I want to be the grandmother I want to be, the sister I want to be, the daughter I want to be.

When Samantha Gonzalez said to me, tell me about your VA care. Out poured the frustration of the gaps in care I outlined.

My medical care San Francisco VA:

2011

May 26 - SFVA ER intake

Jun 1 - SFVA intake

Jun 27 - SFVA women's clinic

July 11 - Zwelling They looked up appointment and said appointment was in the computer for the 12th 9am. I became very upset a social worker saw me and took me into an office he contacted Zwelling who said "it says in my notes I made appointment for 11th" had about 15 minutes to talk with her about finding someone to use the two fee basis appointment. Made appointment for the 25th of July then she called and change appointment to Aug 1 so I could attend a group meeting that day and see her.

Aug 1 - Zwelling called me to say she was going home ill rescheduled for Aug 4 at 2pm. At this point I felt I could not continue to try to see this provider in one month she missed appointment, failed to tell me where her office was, then changed appointment to Aug 4 (what I was wanting her to do is help me find a provider for the fee basis I was given). I felt that after the 20 days of changes missed opportunity and confusion I could not trust her with my mental health care. I communicated this to my primary provider.

The next thing that happened was not a missed appointment but a combination of county budget cuts and lack of services for women in the area.

Aug 10 - signed up for Marin Services for Women

Aug 12 - attended first session of MSW

Aug 15 - attended second session of MSW around 11 am leaders come into the room and say we have announcement the MSW outpatient service is closing in 3 weeks. I was outraged that this group claimed they had no idea until that morning this facility was closing. So then I was left with no fee basis not even the two they had given me and no mental health help. [Exhibit A]

Sep 12 - Dr Hasser (when arrived clerk did not know I had appointment it took about 15 minutes to contact Dr to find out I did have appointment)

Sep 19 - Pain Clinic 4 hr appointment-these 4hour long appointments are very difficult for a person with chronic pain.

Oct 24 - Dr Chin

The following list are appointments with Christine Celio (Post Doctorate Fellow) appointments made in person weekly on Fridays for either 10 or 11 am. She worked in pain clinic. When she asked me what I was trying to gain from sessions my answer was I want to feel safe when I come here. It is a very scary place, many men, early failures, no groups available at a time that would work for me.

Dec 9, Dec 16, Dec 30

2012

Jan 27, Feb 10, Feb 24, Mar 9, Mar 23, Mar 30, Apr 6, Apr 13, Apr 20, May 4, Jun 1, Jun 8, Jun 15.

Jan 23 - Dr at women's clinic the clerk was a not aware had appointment again had to check with Dr, then said oh you do have appointment

May 14 - women's clinic asked for mammogram was told not done every year but every other year. I had a notice from Stanford where I had mammograms since 2004 telling me it was time to do my test. Dr said no, new thing done every other year.

July 25 - VASF Dr Hasser. This appointment was made by phone message left for me by Dr Hasser. When I arrived I was told I did not have appointment Dr with another patient. Showed my notes to clerk about phone messages left for me by Dr Hasser. She said maybe it was not with Dr Hasser and told me there were no appointment for me in system. Left clinic 7 out of 10 angry. I was called back to the clinic saying they would see me.

Aug 8 - VASF Dr Mesa

Aug 22 - VASF Gynecology (resident) was told by Dr only have 15 minutes

Aug 27 - VASF women's clinic

I had shoulder surgery Sept 19 outside of VA care this prevented me from being able to access help. I had learned the year before that fee basis was not going to happen. There are still no services in Marin and choices are gotten slimmer. A few calls to local programs all would require fee on sliding scale basis would not even accept fee basis if available. My mental health was declining more isolation, unable to open mail or answer phone.

Oct 18 - Called for medication refill I left message for Dr Kerlikowske that I was running short and needed her to reorder it so I would get what I needed.

The source of this problem come because the pharmacy will say "we sent you a month's supply the 1st of October so the next should not be sent out until November 1st." The problem with this thinking is if you send me a 30 day supply and there are 31 days in the month I will run out. I was told the only way to get the drug sooner was to call the clinic and ask the doctor for an RX. I told them that is what I had done and they told me she order it to be shipped on Nov 2. I asked that a pharmacist call me to discuss.

Oct 22 - I got a call from the pharmacist my frustration was growing. I was told the Dr had written for me to get the next shipment sent out on November 2nd, now leaving me with 3 days without medication. I was told it was written by the doctor that way and I would have to contact them again. I asked for a face to face meeting with a pharmacist. Told that could not happen for a couple of weeks. So I asked what would happen if it was a new drug for me and I needed information, it would still be a couple of weeks. I got a call back later saying I could not have appointment "it does not meet the requirements" for a face to face meeting. It was the way the doctor ordered it. Also told that if I needed a change I would have to call clinic back. That the doctor had made an error by not ordering it for October 31st. Then I asked if the doctor had ordered 8000mg and it should have been 800mg would you call me and tell me to call the clinic or would the pharmacy take care of the problem before it got to the patient. That ordering the wrong date is just as wrong as ordering the wrong dose.

Oct 23 - got call back from pharmacy (I think Susan) said she would give this to a supervisor.

Oct 23 - I called Patient Advocates office and never got a call back.

Oct 30 - When I received the medication the dosage was changed from 200 mg three times a day to 300 mg two times a day. I called the pharmacy again spoke to Debbie she said "it was reviewed and changed". "It was a dosing adjustment". When I asked why the answer was shocking. They don't want to have so many pills in the pharmacy. I asked if the 200 mg was being taken out of the stock, the answer

was no we sent you a letter to explain. [Exhibit B] At this point I made appointment to see Dr at women's clinic the first available appointment December 3.

Dec 3 - SFVA women's clinic made appointment to discuss the change in dose for my pregabalin the Pharmacy made from 200mg TID (three times a day) to 300mg BID (two times a day)

Dec 7 - received wrong dose of medication. Dr Kerlikowske ordered 200mg BID (two times a day) Called Dr at women's clinic told them about mistake. Did not receive return phone call. [Exhibit C]

Dec 10 - Called women's clinic again, explained their actions were hurting me, causing me to be more emotionally unbalanced because I cannot be sure that anyone is communicating or listening to me. That I had gone to see the dr because of a change made by pharmacy without discussing with either my doctor or myself.

Was called back later by women's clinic nurse she said she was sorry for error and will send what I needed.

Dec 18 - called Pharmacy spoke to Ed to see when I would get the rest of the medication. Timir from the pharmacy called me later to tell me medication was being sent out today.

2013

Jan 28 - SFVA women's clinic to discuss the error that was made when she changed the order that the Pharmacy had changed.

Mar 14 - SRVA intake Nicole Randall Phd fellow said no process groups available maybe in July. No individual therapy available possible 6 month waiting list. Offered Anger management group Friday 2 pm (this is a very difficult time to drive north on highway 101) given paper from last year listing groups that are possible at the SRVA. On the list was the was Women's coping skills show to meet on Tuesday at 11:30

Mar 15 - anger management group- Leader Nicole Randall held in large room where the veterans are all sitting next to each other with our backs to windows. Group leader did little more than read the last lesson in the book. Came time for relaxation exercise that is when I realized the chairs were much too large my feet would not touch the floor when I sat back. I pointed this out to the group leader when I was asked how the relaxation was. I looked for a different size chair in the room and there were none. I am not sure who this room is outfitted for but not a good place for me. It felt again like I was not being considered. That an average height woman 5'5" cannot sit in a chair and have her feet hit the floor. This has never happened to me before in any office I have been in, I was very confused about why we were not able to find a nice small room where we could make eye contact with each other and feel like we are not on display for everyone who walks into the clinic.

Mar 22 - Anger management. Was called at the end of session by Dr Hiroto. Met her after she invited me to a new group starting the next week. I agreed to coming noted it on my calendar but somehow failed to get the time written down.

Mar 25 - called SRVA to confirm group time was told 11:30

Mar 26 - Arrived at SRVA checked in at desk asked where and when the group would start. The man at the desk said they would be meeting in an office right off the lobby at 11:30. At 11:40 went to desk to ask about the group since no one had showed up. The lady I spoke to again said it would be 11:30 in the room off the lobby and pointed where I had been waiting. I told her it was past 11:30 and no one showed. She then got on the phone and asked. She then told me the group was at 2 pm. I got very angry and told her I need to talk to someone right now or I was going to be 10 out of 10 angry. At that point the security guard came over and said "we not going to have that in here". I assured him I would leave if I got to a 10. Let me add I made no threat other than I was angry and needed to see a person. A few minutes later Dr Hiroto came out and started to talk to me in the lobby. I asked her to join me in the conference room. I told her about all the mistakes that had been made that are listed here. How frustrated I have been because of the chronic pain from multiple sources. That just driving an hour sitting and hour and then driving an hour would not help me. That I need help in my county within a 10 to 15 minute drive. I am sure I did not make a good impression. I called patient advocate office to ask them to document yet another appointment that was miss-handled.

Mar 27 - received phone call from Megan McCarthy. Explained all of the above briefly told her the problem is I need relevant content. Not basic skills. I need process group and individual therapy. She said these are not available long waiting list. We discussed the idea of me using my Medicare benefits to have someone in my community help me.

I am not sure who I spoke to but I was asked if I would take an appointment with a doctor. The person asked me if I would come up to Santa Rosa and have a Skype with a Doctor in San Francisco. I asked why I could not drive to San Francisco to see him there it seemed silly to drive 40 miles to Skype with someone who is working 35 miles from me in the other direction. I was then given an appointment to see Dr Threllfall in Santa Rosa April 10 at 9 am. I asked if that was the only time I could come. I was told that this kind of appointment was always at 9 am.

April 10 - arrived just before 9 am checked in at desk told to go to waiting area. I waited for 45 minutes before I went back to the desk. I was told they would contact the doctor to go back and wait. About 5 minutes later I was called in to the office. Dr Threllfall said he was sorry but he did not know he had an appointment.

{a side note here after he said that all I could think was, you work for the VA, mental health is overwhelmed to point of no appointments available, this is not just a problem here by VA wide and has been in the news, why would you be here getting a paycheck if you did not have appointments at 9 am on a Wednesday.}

The session was a disaster, he asked why I was there. I told him about the mix up with appointment that the VA is not just not helping me but it is hurting me. He left the room several time and each time returned asked another question that I know I have answered many times and should be well documented. Things like, how was your childhood? Do you have hallucinations? What medication are you on? What is the biggest problem for you today? I told him anxiety due to my lack of care and being forgotten and pushed under the rug again just like when I was raped, not just by him today but by the system. He gave me a prescriptions. I never took it, why should I need to be medicated when they system is failing me.

Apr 11 - received a call from Chantell asking me to make appointment with Dr Threllfall. I told her that he gave me a pink paper to take to the front desk. I did and they gave me an appointment card for the date and time she was trying to make the appointment for. I told her this is really shaking my confidence if the Dr first "doesn't know he had an appointment then forgets that he made appointment with me in his office.

I refused to see him again.

May 8 - Still in need of care I made contact with the Cheryl Wernell Women Veteran Coordinator. Explained the difficulty I was having both getting to the VA facility and the problems I have had when I go there. She said she would make attempt to get me fee basis again. The fee basis is not useful to me unless there is a person who will take it for payment. I explained that I was not able to call every provider in Marin County to find one who would and I needed help with this. She said she would ask around and call me back.

May 22 - Another call with Cheryl Wernell she gave me the news that the fee basis for 2 visits was approved she did not know how long it would take to get it mailed out. She gave me 2 names. I watched my mail very closely the next few weeks finally on June 18 I had still not received the fee basis papers called Cheryl Wernell again. She told me that the fee basis had expired but she would see if she could get it extended. I finally got a copy in the mail on June 22nd. It was postmarked June 19th It was extended until July 17th. When I called the number I was given one was disconnected the other called back after three phone calls in a week and said I had to pay a fee of \$450 for the 1st visit and \$280 for each session and she would not take the fee basis as payment.

Jun 18 - called to get refill on prescriptions had to call women's clinic I cannot just call the pharmacy for a refill of pregabalin

July 1 - had not received medications so called to see why. I was told they were never got the message. I called again on July 8 and was told first that it went out Friday, then after checking the pharmacist said it was filled on Friday but was being mailed on the 8th. Received on the 9th of July.

I have kept notes both on my calendar and in notebooks. I have copies to back up everything I have said here. I am sure the medical records do not contain the information about the mix ups and my impression of my care at the San Francisco VA. Along the way I tried to contact the patient advocate. Many of my messages

were not answered I received a letter from the Chief of Quality Management to apologize for some of these events. [Exhibit D]

Summary: the act of trying to get care that meets me where I am as a patient is not happening. The system is out of touch and things as simple as the pharmacy emailing a doctor about a problem is not the policy. When I am told to come back in three months cannot make appointment in person before I leave the answer is "we will send you a card to remind you to make appointment". When you get the card in three months it takes 6 weeks after that to get an appointment. That makes it really 4 and 1/2 months not 3. This starts the cycle all over. I was told at one point that the Women's Clinic Doctor is only in on Monday and Thursday. The rest of the time she does research. The system is set up to fail. The failures of the caregivers I have had in the last 2 years is unacceptable. If you look at appointments that I made over the phone or were made for me out of twenty one, seven of them had major problems that triggered me and made my life more difficult. That is 1/3 of my appointments causing problems not making them better. The only successful time was when I was the 17 appointments every Friday in the pain clinic. When I made the appointment face to face for the next week. This was just a temporary help not long term supportive and not a trauma processing time. It was with a doctorate fellow (in training) and her time was done there. Continuity of care cannot be given by student that leave after a few months. In mental health care it takes time to trust both the care giver and people you meet while getting care in a group setting.

Everything that has occurred from my first visit when I was told the patients park in the overflow and take a bus from there. (I am not getting on a shuttle bus with a bunch of men). My question why don't the employees park there? To quote the phone message you get when you call "where we put veterans first". If you put them first there would be parking for them and the employees would take a shuttle bus. To the pharmacy policy to have the patient correct doctor/pharmacy miscalculations. No groups No individual therapy. No fee basis. "Where we put veterans first"? It seems the veteran is last, and women veterans don't even make the list. Called Mister, having to wade through a sea of men for every appointment. The first appointment I had at the women's clinic there were only 4 chairs 3 of them taken by men, yes 3 out of 4 chairs filled with men inside the women's clinic. I am not last I am not even on the list

One constant idea that I find unable to rectify is the physician says it is a mental health issue, the psychologist, or psychiatrist say it is in your body. I have to remind them both that I can't take off my head when I walk into the Dr for medical care and leave my body behind when I walk into mental health care. The concept of a whole body thereby a holistic approach is out the window. Everyone has a specialty and you can only talk about the one problem. I went to a specialist, well specialist in training and was told very clearly that I was only allowed 15 minutes for an exam. When the doctors at the VA spend their time supervising students we are paying them to teach not give care. A veteran sees a student the supervising Dr will look at the notes signs off and never looks at the patient. The students do not know how to put appointments into the computer. Student care is not giving the veteran the best. Things like acupuncture and chiropractic care are either offered at the VA or fee basis are given for these things. I have seen Osteopaths for over 20 years on a nearly monthly basis. I know without asking that fee basis would never be considered for that care. It is very helpful to me and calms both the tension in my body and mind. I am lucky I have other insurance that takes care of me. Not all veterans are as lucky as I am.

Another problem is the idea that you must get help for substance abuse before you get help for being raped. The substance abuse is to kill the pain. You want them to give up the pain killer before they get help for the problem which they are killing the pain. It would be like saying. I will fix your broken leg if you walk over here close enough.

The entire VA application process feels like a dance. You have to ask for things a certain way, on certain forms, asking for certain forms. The military and the VA have access to all those files so it felt like I was playing guess what we have and guess form it is on, guess how you have to ask for it. This is the reason the backlog exists. If a trained professional sat down with the records and the veteran it could be a simpler process. The way that files disappear or pages get taken out of medical records makes the job harder for the Veteran and anyone helping them find ways to prove claims. It should not take an act of a congressperson to get files about criminal actions or medical visits while on active duty. When I saw my file at the C&P I was finally given after over 3 years it was 2 feet high.

The collection of information process can include things like in my case. I was unable to access any of the medical records from the time I was a dependent of active duty. There was no way for me to request these records without his social security number. Almost 10 years of my medical history was lost. The critical years just after my rape. I was lucky that the Criminal Investment report was still available. It took two letters to Congressman Honda to get these files that proved my claim. Even then the 1st C&P gave me a rating of 50%. My counselor wrote a letter as soon as she saw it and said the rater was wrong. That my symptoms were more severe, more often, and unrelenting. Even though I put on a brave face all the symptoms of PTSD plague me. Hyper arousal, depression, fear, avoiding everything even fun things. Flashbacks where I feel trapped in the room again with man who raped me, I can see his face and smell the smell of old tents. Isolation from people I love like my son and daughter, granddaughter, mother, sisters, not being able to maintain an intimate relationship. I have been married three times and find now I don't want anyone to invade the safe space. The emotional roller coaster of feelings never knowing if in an hour something someone says will cause me to become angry. When a system fails it takes me back to the place where the commanders had me in a room telling me they knew what was best.

A suggestion I would like to put forth is the idea of Mental Health days while on active duty. Where a combination of tests and talking to mental health professionals. Most of the people affected by PTSD are young and too proud to ask for help. The stigma of needing mental help would be removed because everyone does it. Early signs of traumatic brain injury, depression, sexual assaults, and battle PTSD are difficult to diagnose without a trained professional. The tests can be made that will show signs of all the problems that plague our active duty military people. The talking can help unit cohesion instead of picking on the ones who seem troubled the unit can get behind the person in need. You do not have to wait until someone is suicidal to help. Just like you don't send someone into battle without body armor and a gun. Sending young people in harm's way without mental health care is reckless. We know better now so we need to do better. Getting to the patient sooner improves the outcomes. There is no disease that I know of that will get better by ignoring the obvious problems. Natural disasters, bombing, mass shooting when these happen trained mental health people are sent in to the patients as soon as possible. It has shown that to improve symptoms of PTSD in all age groups.

Enclosures: Exhibits A–D

Prepared Statement of Lisa A. Wilken

I am a USAF Veteran. I was medically separated from the USAF after a sexual assault and am currently rated 100% Service Connected Disabled by the DVA. I am a wife of almost 18 years to my wonderful husband, Robert. We have been blessed with two sons, Joel, 12 and Benjamin, 3. I do Veteran Advocacy as a volunteer.

Thank you for giving me the opportunity to speak with you. I am a USAF Veteran and I am rated 100% Service Connected and I am a MST Veteran. I have struggled for many years to be proud of my service because of my experience, but by speaking out about my experience I hope to make a difference so that another young person in uniform won't feel the way I did for so long. I was 22 years old when I was raped. I am 42 now and a wife and mother of two sons. Not a day passes that I don't deal with something related to the assault.

Why is it so long lasting? I believe due to it not being treated properly from the time of the assault compounded the problem and lack of services by DOD magnifies the problem and by the time the VA receives us we are already behind in our recovery. Studies show that women are at a higher risk for PTSD due to trauma if their experience was severe or life threatening, were sexually assaulted, were injured, reacted severely at the time or experienced stressful events after the event or if there isn't a good social support network. MST Veterans have had all of those things on top of their assault.

Study us while we are in treatment. Studies are needed, but treatment needs to come with those studies.

We need groups at VAMC's and outside facilities. You will hear me bring up using our civilian medical professionals a lot. Some women are not going to come to the VA because of lack of treatment or a bad experience with the VA. Most people who have never been in the military don't realize how much the VA system mirrors it. That can be a negative when trying to get a MST Veteran to come in for treatment. There are programs for treatment through the VA, but there are not many and they

are 6 weeks long. What mother can leave their family and would an employer tolerate it? What about shorter, more intensive therapy weekends that give MST Veterans the tools they need to deal with the results of years of unattended PTSD. There are things that need attention in most of their lives that are a result of their PTSD due to MST and some of them don't make the connection or realize that it can be better if they have the tools. Some have no support network and that is something that is crucial. To have someone to talk to about things you can't talk about with your spouse can save lives. Events could be held through each VAMC and coordinated with local health care providers. Using outside health care providers I believe would be a great asset to getting more women in for treatment and have a higher success rate as a local provider may not trigger a trust issue that the VAMC may pose to a MST Veteran. I believe if you open up treatment for MST Veterans to go outside of the VA you will see a larger number of Veterans apply for those services.

Protocols need to be developed for MST Veterans and follow up to ensure that VAMC employees understand PTSD due to MST and are aware of the Veterans they are giving care to and following VAMC standards. I hear from many women of how their MST symptoms are overlooked or even ignored while in VAMC's on other wards, but also when inpatient on psychiatric units. Group therapy requirements for MST Veterans need to be looked at. If you don't participate in group, you are seen as not cooperative; when it is just that you are not going to talk in an open group. Sleeping in a room with a stranger can be a problem. Some MST Veterans still sleep with the light or the TV or some sort of distraction mechanism to get to sleep. To be required to sleep with a stranger in your room, even of the same sex, can sometimes trigger other PTSD symptoms. Nightly checks of rooms that are done can trigger an MST Veteran. These are a few examples of issues that arise due to VAMC employees not being trained or recognizing MST Veteran issues.

As always, more GYN services need to be available at each VAMC, but here again is an area that our local medical community should be utilized.

Therapy for family and spouses is needed to help them to understand why they see some of the things they do and understand what is happening. Someone for family members to ask questions of other than their parents who are struggling with getting the answers right. Kids see and know more than any of us realize and sometimes when it is realized, it is too late and damage is done. My 12 year old son Joel has seen his mother many times upset or angry for reasons he is too young to understand fully.

Spouses need a support network also. Some may need more than others, but it takes a strong person to put up with PTSD from MST. There is no reasoning with PTSD. No matter how much love you give it, sometimes it won't let an MST Veteran love you back. Intimacy issues need to be addressed. It is an important part of marriage and is affected either physically or emotionally.

MST coordinators at VAMC need help. I am not sure if there is one at each facility, but I do know some have other duties. Our MST Coordinator, Laura Malone, is wonderful, but we need help for her. She is one lady and is overworked and under recognized for what all she does and for how many MST Veterans she helps and their families.

I can't stress enough how utilizing our local medical communities could be the answer to help the VA deal with the much needed addition of more treatment for MST. As always, money will be a big factor, but if the problem is going to be addressed, money will be spent on adding services at VAMC's or utilizing our civilian medical community and their expertise. It may also serve a dual role and get more people informed about issues facing our men and women who volunteer to serve in our all voluntary forces.

Thank you for your time.

Lisa A. Wilken

Prepared Statement of Brian Lewis

Chairman Benishek, Ranking Member Brownley, and Distinguished Members of this Subcommittee;

It is a privilege and honor to be the first male survivor of military sexual trauma to testify before the Subcommittee about this issue. I would like to thank my partner Andy who could not be here today. I want to make it clear that I am not here representing the gay and/or lesbian community or their issues. I am here as a veteran who was raped while I was active duty. Our significant others allow us to do so much and receive so little credit for their sacrifices. I would also like to thank

the subcommittee for treating the issue of military sexual trauma in a gender inclusive way. This places the subcommittee farther ahead than the White House, and very much ahead of the Veterans Health Administration. Indeed, the VHA discriminates against male survivors of military sexual trauma because of their gender in a multitude of ways and this is a practice that needs to be brought to light and stopped by this committee.

I was raped while serving aboard the USS FRANK CABLE (AS-40). I was discharged a year later after a Navy psychiatrist determined I was suffering from a Personality Disorder. After moving home and almost committing suicide multiple times, I turned to the Veterans Health Administration for assistance with my post-traumatic stress disorder. It was almost 6 years before I received PTSD specific care.

Residential Care

Currently the Veterans Health Administration operates about twenty-four residential treatment programs for posttraumatic stress disorder. Only about twelve are designed specifically for the treatment of military sexual trauma. Of the twelve designed specifically for victims of sexual trauma, only one accepts male patients. That facility, the Center for Sexual Trauma Services at VAMC Bay Pines, is coeducational. Put simply, male survivors have no single gender residential program designed specifically for survivors of military sexual trauma. A complete listing is attached as Exhibit "A" to my written testimony. The Veterans Health Administration should not officially sanction gender discrimination.

Information on these programs is very hard to obtain. Three days before this hearing, I used the PTSD Locator on the National Center for PTSD's webpage to find programs treating exclusively military sexual trauma. I used Bay Pines' PTSD program as a baseline because I knew where it was and its mission. I was not able to access a separate listing for programs dealing exclusively with military sexual trauma. In fact, when I clicked on the state of Florida, the Bay Pines program is listed as a Women's Trauma Recovery Program (Inpatient).¹ For a male survivor, knowing his services are received through a women's program is very demoralizing and discriminatory. More often than not, there is no printed listing available as to what programs specifically serve military sexual trauma survivors. For veterans without Internet access, a printed listing may be the only hope they have of accessing residential care for their military sexual trauma. We strongly recommend that each Military Sexual Trauma Coordinator be required to keep hard copies of a list promulgated by the Veterans Health Administration as to what programs are available to treat military sexual trauma.

I attended the Bay Pines VA Center for Sexual Trauma Services residential program in June 2009. I attended this program because it was and is the only residential program specific to military sexual trauma that male survivors can access in the Veterans Health Administration. Unfortunately, upon arrival I discovered the program was co-educational. This presented many barriers to effective treatment in that program. I witnessed men and women engaging in romantic liaisons during their participation in the program. These emotional entanglements proved to be a distraction to many survivors who were in the program with me at the time. I personally was uncomfortable sharing the details of my trauma in the same group where women were present. I can only imagine the damage which would be caused by requiring a male survivor whose perpetrator was a woman to attend an integrated program. Upon discharge from this program, they failed to ensure a mental health provider was following me. This caused me significant setbacks because I had to wait almost two months to be seen after returning to Baltimore and became suicidal during the time I was waiting for care.

Outpatient Care

In the outpatient environment, I have received less than stellar care. Until this year, the Baltimore Division of the VA Maryland Health Care System did not have an outpatient group for male MST survivors. This same VA hospital has had a group for female survivors for several years. When I asked about joining the female MST group, I was denied for no other reason than I was a man. I was forced into mixed trauma groups. These groups permitted me no opportunity to discuss my personal trauma. I also felt stigmatized by the combat veterans there. In one mixed trauma group, the facilitator allowed the combat veterans to bring up their trauma because "the VA focuses on combat issues" in her words.

The Veterans Health Administration has very few resources outside the residential treatment setting for male survivors of military sexual trauma. Outpatient

¹<http://www.va.gov/directory/guide/state-PTSD.cfm?State=FL> (accessed July 16, 2013)

groups are common for female survivors of military sexual trauma. However, very few groups are available for male survivors. I consistently hear from male survivors seeking peer support groups. The groups that male survivors can attend are more often than not a more general PTSD group where combat veterans are mixed with sexual trauma survivors. In these general groups, generally no sharing of the reason behind the PTSD is permitted. This marginalizes male survivors by forcing them to maintain their silence about their experience.

Overall Supervision

The overall supervision of military sexual trauma programs within the Veterans Health Administration is vested in the Director of Women's Mental Health, Family Services, and Military Sexual Trauma. This oversight denigrates the experience of male survivors and reinforces the concept that military sexual trauma is a "women's issue." We strongly urge that military sexual trauma be created as an independent directorate within the Veterans Health Administration.

Within the VHA, an overwhelming majority of Military Sexual Trauma Coordinators are women. Especially in the case of men who are assaulted by women, this presents an often-insurmountable barrier to care. We recommend that there be both a male and female MST coordinator in each facility.

Research and Training

More research needs to be conducted by the Veterans Health Administration concerning male military sexual trauma. Currently there is very little literature available on successfully treating male survivors of adult sexual assault.

The current sequester mandated by the Budget Control Act is harming our veterans in an indirect way through the training budget. Direct care providers are finding it difficult to attend training necessary to keep current on the latest information available in treating survivors.

Personality Disorders

I urge the Subcommittee members to support H.R. 975, the Servicemember Mental Health Review Act, offered by Rep. Tim Walz (D-MN 1). This legislation would give veterans, like myself, who have been misdiagnosed with personality disorders the opportunity to apply for a potential military retirement from the Department of Defense. Utilizing TRICARE for military sexual trauma related care could remove some of the cost of providing that care from the Veterans Health Administration, which is currently estimated at \$872 million.

This diagnosis made it hard for me to receive VHA care at first. This diagnosis creates a stigma around the survivor as a condition that predates service. I have even heard survivors tell me they have been denied military sexual trauma related services at the DC VA Medical Center because of their erroneous personality disorder diagnosis. In fact, the Topeka, Kansas Stress Disorder Treatment Program requires veterans to furnish a copy of their DD-214 in order to access treatment and explain on their application why they received a less than fully honorable service characterization. This application is attached as Exhibit "B" to my testimony. With these facts in mind, I fear for what kind of reception I will receive at the Minneapolis VA Medical Center when I move there. Will I be denied MST services there because of an erroneous medical diagnosis designed to save the military money?

Conclusion

In the last few years I have done much to better my life. I graduated in May 2013, from Stevenson University with a Bachelor of Science degree in Paralegal Studies. My master's thesis on military sexual trauma is under consideration for publication in Stevenson University's Forensic Journal. I will graduate in December with my Master of Science degree in Forensic Studies. I will apply to attend Hamline University School of Law in Saint Paul, Minnesota, next year. I help administrate MenThriving.org, an online community designed to help men heal from the wounds of sexual trauma whenever received. I am an Advocacy Committee member with Protect our Defenders, an organization dedicated to transformational change in the military's handling of sexual assault. I am the President of Men Recovering from Military Sexual Trauma, a group dedicated to advocating for and raising awareness of male survivors of military sexual trauma. Unfortunately, these accomplishments are not the result of treatment provided by the Veterans Health Administration. This progress is the result of finding nonprofits dedicated to helping survivors in general, building resources to address the lack of current credible resources available for male survivors, and finding other survivors to help support me as I struggle, and finding a partner who has stayed by my side regardless of all the hurt I have caused.

The Veterans Health Administration fundamentally fails male survivors of military sexual trauma every single day. They have proven their inability to adequately care for us. We respectfully request Congress to legislate equality in practice for male survivors of military sexual trauma.

Prepared Statement of Tara Johnson

Chairman Benishek, Ranking Member Brownley, and members of the Subcommittee, I am honored and grateful to have the opportunity to speak to you today regarding my experiences with Military Sexual Trauma and care and treatment from the Department of Veterans Affairs. I proudly served in the United States Marine Corps for ten years and achieved the rank of Major. While no longer in the Marine Corps, I am now employed as an Army Wounded Warrior Advocate, serving severely wounded Army veterans and families. It is not my intent to discredit the Marine Corps and the Department of Veterans Affairs. It is my goal to bring awareness to critical areas that require improvement, in order to better serve our Veteran population.

While in college, I decided I would be honored to serve my country. I decided on the United States Marine Corps because it was, I believed, the most challenging and the best branch of service. I experienced my first incident of Military Sexual Trauma as an Officer Candidate. This incident was a sexual assault by a senior Officer. Throughout my career in the Marine Corps, I endured several more incidents of MST and witnessed other Marines suffer from incidents of MST. These incidents included assaults, attempted assaults, abuse and harassment. I did not disclose my experiences, as I had seen the unfair treatment of those who had disclosed incidents to their commands. Despite these incidents, I excelled in the Marine Corps and lived the motto so familiar to Marines of "suck it up and press on".

I spent almost 8 years on Active Duty and returned after my children were born, to serve as a Reservist on Active Duty in 2009 to work with severely wounded Marine Veterans and their families. I again experienced incidents of MST, and began suffering depression, anxiety, panic attacks, increasing self-doubt and disgust with the situation. During this period of Active Duty, I did find the courage to approach my command regarding these incidents. It was not a positive experience for me to say the least. My statements were dismissed by my chain of command. Because I had approached my command, and nothing was done, I endured more harassment and abuse. During this period I was also in the midst of a divorce from another active duty Marine. I endured incidents of harassment and abuse from him as well as his counterparts who shared my work space and some who were in my direct chain of command. I sought and received medical treatment for panic attacks, but was never asked about MST by medical personnel. I was put on daily medication to relieve depression and anxiety. I requested early release from my Active Duty orders because the situation became so difficult, I truly felt I could no longer endure and was discharged from the Marine Corps in August 2010. The request to terminate my orders early, prior to obtaining full time employment and VA Care and Compensation placed me, as well as my children in an extremely fragile financial and emotional state for a significant amount of time, however I could not tolerate the continuous feeling of being belittled and victimized. I felt I had to protect myself, as well as my children, as they deserved a consistent, loving mother who was not afraid to go to work and did not suffer episodes of panic in their presence. I have since been offered opportunities to return to Active Duty and though I respect the Marine Corps, I am no longer able to return due to these experiences. The complete pride I have felt as a Marine in the past is now riddled with shame, self-doubt, distrust and financial stress and uncertainty.

In October 2010, I sought treatment from the Madison, Wisconsin VA Medical Center. I was able to receive extremely limited treatment for depression, anxiety and panic. Treatment mainly consisted of prescribing medications. I dutifully completed the PTSD questionnaire at each appointment, and while it was evident I suffered from severe symptoms of PTSD, I was never asked by a provider if I had experienced MST. While I truly understand that the VA's focus is on our OEF/OIF Combat Veterans, and do not want to minimize their need for treatment, I believe someone should have asked me, based on my lack of recent combat deployments and my symptoms. I pride myself in being a very strong woman, and when I was not asked about MST, I did not feel it was appropriate to reveal this information. I was also put on different medications throughout the next few months, some of which actually increased my depression. For the first time in my life I contemplated suicide, but knew I needed to continue to cope for the sake of my children. I did disclose

that I had thoughts of suicide to my psychiatrist, but did also assure her that I did not have an actual plan. While this psychiatrist was responsive and helpful, it was extremely difficult for me to receive consistent treatment at this time, as I was not yet service connected, and received little to no medication monitoring.

In December 2010, I had my Compensation and Pension Exam for Mental Health. I entered this exam with hope that someone would ask about MST and I would finally be relieved of the secret I had held for so long, and then receive help. I was “examined” by a male psychologist. The doctor spent twenty minutes with me. He was extremely abrupt and impersonal, and did not once ask me about anything related to MST. Again, I did not feel this was a safe environment to disclose my experiences. He ended our appointment very quickly, stating he was going out of town for the weekend, stating he was “sure I would be fine”. My hope deflated. I recall sitting in my car almost an hour in the parking lot, before I felt I could even drive. This appointment set the precedent for what I felt I could and should say to the VA.

I was not able to receive counseling throughout the next few months, as I was waiting for my service connection. I was informed that I would have to pay for any care I did receive from the VA during this interim period, and I was not yet financially stable and could not afford extra costs. I did finally contact the Transition Patient Advocate at Madison and disclosed my MST experience. He immediately took action, and attempted to contact the Regional Office to have MST added to my claim. The Regional Office directed me to prepare and submit a statement that described the details of my assault and other MST incidents. Though extremely difficult, I completed and submitted this statement to the Milwaukee Regional Office. I became hopeful that I would be able to receive another examination where I could disclose my experiences, but despite fulfilling their request, I was not granted another exam. I continued to struggle with symptoms and memories as well as side effects from medications. Because MST was not addressed in any of my exams, I was not able to utilize the local Vet Center. I even spoke with a local Vet Center provider regarding our military experiences. I did mention that I was enrolled at the VA, but was having a difficult time obtaining appointments. The provider then said “Well, you are not a combat veteran, or a victim of MST so you cannot come to the Vet Center”. I remember feeling very discouraged that she had just assumed I had no experience with MST, and if she said that to me, then how many others had she said this to? I would have entered treatment outside of the VA, but I did not have private health insurance at this time.

I was able to meet with a provider months later in Spring 2011, after I became service connected. My appointment was an intake for the PTSD Program. I was not asked about MST by the provider, but finally disclosed that I believed I had experienced MST. I was extremely detailed and candid with this provider for over an hour, in hopes I would receive treatment. When this appointment concluded, the provider informed me that I did appear to have severe PTSD and would benefit from treatment. As she said that, I felt a weight had been taking off my shoulders, and relief that I would get help. I was then informed the “wait list” for consistent PTSD treatment was four months. I remember feeling completely deflated, that I had opened up and would have to wait for treatment.

I was afforded the opportunity to meet with a part time provider for counseling at this time. This provider was only there twice a week. I was a single parent and worked part time, so it was extremely difficult to schedule consistent appointments. I was not afforded any alternatives by the VA. There were several instances where I would take time off work and arrive at an appointment only to be told it had been cancelled, even though I had not received a cancellation call from VA. I was also made aware that even though the hospital had cancelled these appointments, my Patient Record reflected I had “no-showed” or cancelled myself. This was simply not the truth, and I grew more distrustful and frustrated. I was also told I should engage in Prolonged Exposure Therapy. I explained to the provider that I was afraid to do this type of therapy, as I was concerned it would increase my symptoms and impact my ability as a mother and at my job if I was having increased panic attacks. I was subsequently informed I was “non-compliant”. I stopped seeking treatment at the VA following this experience.

During this period, I had also received limited primary care at the VA, through the Women’s Health program. I was treated for simple medical issues as well as gynecological care. No provider ever asked if I had experienced MST, though several of my conditions have been directly correlated with MST. It was during this period that I was also employed at the VA, in the Women’s Health Program. The primary focus of this program appeared to be the monthly number of women Veterans who had mammograms and pap smears. I was given the mission to ensure we met our numbers for completed mammograms and pap smears as if the survival of this pro-

gram was dependent upon those statistics. There was no mention of MST, and though there was a MST Program Manager at this hospital I had never spoken with her, nor had I ever seen the Women's Health Program and the MST Program collaborate in any way. This lack of awareness further proved to me that MST continued to be shameful and was not to be acknowledged. I attempted to speak with the program manager several times regarding the need to address the issue of MST with our woman veterans, but was unsuccessful.

I obtained full time employment in June 2011, serving severely injured Veterans and their families. I began to feel stronger and more confident each day, despite lack of real PTSD/MST Treatment. In spring 2012, I attempted to engage in treatment at the VA once again. I was assigned to a male provider, who was new to this particular VA. During my first appointment, through tears and fear, I disclosed my first experience regarding MST. I informed this provider that I believed I had been sexually assaulted. The provider looked at me, widened his eyes and asked, "Well, do you really think you were raped?" I could not bring myself to return to him or the VA and it was at this time I began to utilize my private insurance to receive therapy. I now pay out of pocket to receive care.

Based on my experiences, and those of other women Veterans I have spoken with, I recommend the VA reconsider their approach to MST screening, acknowledgement and treatment. The VA needs to strive to be a safe environment where MST is acknowledged. If I had been asked about my experiences with MST, I would have been relieved to speak of my experiences, but I was not asked. MST should also be consistently addressed, as PTSD is, so that Veterans who require more time to build trust with VA Providers, have the opportunity to do so, before they disclose their experiences. It is my opinion that VA providers should be experienced and or educated in military culture, especially for women. Veterans should be afforded greater access to care and flexibility in scheduling and receiving care. Veterans deserve the ability to advocate on their own behalf regarding types of therapy, as what may work for some, does not work for all.

MST needs to be acknowledged and addressed in the primary care setting as well. There are direct correlations between certain medical conditions and MST, such as Fibromyalgia, GYN issues, headaches, fatigue, substance abuse and eating disorders. When a Veteran presents with a specific physical symptom or clusters of symptoms providers must be ready to assess, identify and acknowledge the possibility of MST, and initiate screening.

My experiences with MST were extremely difficult to acknowledge. I was in denial for many years. I witnessed many other women endure various incidents while in the military. It became 'the way it was'. Experiences such as this have the ability to change the way even a very strong person perceives themselves. It creates self-doubt and distrust not just strangers, but people who say they are "here to help". When I had appointments at the VA where MST was not addressed and/or acknowledged, I felt victimized and belittled again. MST has lifelong effects, and is truly an invisible wound. Just recently, I had difficulty completing annual Sexual Harassment and Prevention training, required by my employer. During this instruction we were shown a "YouTube" video of a young soldier who had a similar MST experience. For the remainder of that day, I was agitated and anxious which affected my ability to serve other Veterans. As I stated earlier, I am a strong woman and I am still surprised when I am affected like this.

MST has become part of my life and part of the woman and mother I am today. While I never expected the VA to take care of me completely, that is ultimately my responsibility, I yearned for validation in a safe environment. I did not get this. I am not here today for me. I am here for those who are not ready to tell their stories and those who have not been given the opportunity to tell their stories. I am here for those who have survived MST and those who will experience MST. MST does not just affect individual Veterans; it affects their families, children and our society as a whole. I am not able to get back time I have lost with my children due to severe side effects from medications, panic attacks or traveling to appointments that had been cancelled. It is my hope to prevent another Veteran from losing that precious time. I thank you for your time and I am grateful for the opportunity to tell of my experiences, in hopes it will improve the care that other Veterans receive from the VA.

Prepared Statement of Michael L. Shepherd, M.D.

Mr. Chairman, Ranking Member Brownley, and Members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General report, In-

patient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma (December 2012), and the care and treatment available to survivors of military sexual trauma (MST). I am accompanied today by Ms. Karen McGoff-Yost, Associate Director, Bay Pines Office of Healthcare Inspections.

BACKGROUND

The Veterans Health Administration (VHA) estimates that approximately one in every five female veterans enrolled in VHA responded “yes” when screened for MST. MST is not a diagnosis in itself. It is an experience that is associated with patterns of psychological and/or physical symptoms. MST is a predictor of psychological distress and is associated with several mental health (MH) diagnoses, most frequently Post-Traumatic Stress Disorder (PTSD). Research on the effects of trauma has found that the experience of rape can be equal to or greater than other stressors, including combat exposure, in the risk of developing PTSD. MST has also been linked to an increased likelihood of diagnoses of anxiety disorders, depressive disorders, eating disorders, bipolar disorder, substance use disorders, and personality disorders.

Not everyone experiencing MST will have the same response. Some individuals who have been victims of traumatic experiences, including MST, develop few symptoms. Others develop severe and complex chronic physical and MH issues. Because the experience of MST may result in a range of physical and psychological symptoms, treatment related to MST may occur in a variety of clinical settings depending on the individual’s needs.

VHA requires that veterans and eligible individuals have access to residential or inpatient programs that are able to provide specialized MST-related MH care, when clinically needed, for conditions resulting from MST. Residential programs (also known as MH Residential Rehabilitation Treatment Programs) generally offer more intensive treatment than typical outpatient MH programs.

In response to a request from the United States Senate Committee on Veterans’ Affairs, we reviewed 14 inpatient/residential programs from a list compiled by VHA’s MST Support Team that identified themselves “as having expertise with MST and/or sexual trauma more generally and the ability to provide treatment targeting these issues in a residential or inpatient setting.” Because the request was specific to services available to women veterans who experienced military sexual trauma, the scope of our inspection focused on the care provided to a cohort of female veterans prior to, during, and after discharge from these programs. While male veterans were not within the scope of our review, we want to take this opportunity to acknowledge the incidence and distressing impact of military sexual trauma on both female and male survivors.

We reviewed the electronic health records (EHR) of 166 female veterans with a history of MST who were discharged from these programs during the 6-month period between October 1, 2011, and March 31, 2012. Patients were included if they met the eligibility criteria for MST-related care as defined by VHA Directive 2010-033, MST Programming. As a result, we included five women who were not veterans; three women who were active-duty military; and two who had served in the Reserves but were otherwise ineligible for VHA care. We also visited eight program sites representing a mix of geographic regions, facility sizes and complexities, and urban and rural locations.

Inspection objectives were to describe the nature of services provided to these veterans, the characteristics of these veterans, the characteristics of providers, and geographic referral patterns and factors influencing access. We also assessed compliance with VHA requirements pertaining to MST care.

The programs highlighted in this inspection represent a higher intensity of care provision than utilized by patients with a history of MST who seek only outpatient treatment. While not covering the entire population of female veterans who have experienced MST, the review provides valuable insights into the clinical complexity, access, and care issues impacting veterans with MST.

INSPECTION RESULTS

Patient Age and Service Era

Patients ranged in age from 23 to 65 years with an average age of 44 years old. The most common age range was 46 to 50 years. Slightly less than 4 percent of participants were 25 years old or younger and 4 percent were between 61 and 65 years old. In terms of service era, 38 percent of patients served in the post-Vietnam era, 27 percent each in the Persian Gulf War and Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) service eras, and 6 percent during the Vietnam era. Among the 44 OEF/OIF/OND-era patients, ages

ranged from 23 to 51 years with an average age of 34. These patients represent veterans who served in the military during the OEF/OIF/OND-era whether or not they were deployed. A few had also served in prior eras but for purposes of the review, patients were categorized by their most recent era of service.

Mental Health Diagnoses

The patients in our review were clinically complex and most had multiple mental health diagnoses. PTSD, depression, and alcohol/substance use or dependence were the most common diagnoses. Ninety-six percent of patients had a diagnosis of PTSD, 63 percent had been diagnosed with a depressive disorder, and 70 percent had an alcohol or substance use disorder. Approximately 27 percent of patients also had a diagnosis of borderline personality disorder, further adding to the complexity of clinical presentation. Only 4 percent of patients had a single MH diagnosis. The remaining 96 percent had two or more MH conditions. Of the 160 women with PTSD, only four had this as a sole diagnosis. All of the women with an alcohol and/or substance use disorder were dually diagnosed with one or more MH conditions. Additionally, 13 patients were diagnosed with some form of eating disorder.

Parental, Employment, and Housing Status

Because parental responsibility and job commitments could be factors affecting participation in a treatment program lasting several weeks or months, we examined the percentage of patients with responsibility for minor children and/or who were employed at the time of admission. Approximately 16 percent of the 166 patients were responsible for the care of minor children, and only approximately 5 percent were employed. Nineteen percent of patients in our review were homeless at the time of program admission.

Service Connection

Seventy-one percent of participants in our review were service-connected for any condition (physical or mental health-related) and 55 percent were service-connected for a MH condition.

VHA Treatment Preceding Program Admission

We reviewed aspects of patients' MH care immediately prior to residential program treatment. We found almost 90 percent received outpatient VA MH treatment in the 3-month period preceding program participation. Of the patients not in outpatient care just prior to admission, approximately two-thirds were either in another residential program or were receiving treatment on an acute mental health unit. Most patients received outpatient treatment solely at a VA Medical Center (VAMC) or a Community Based Outpatient Clinic (CBOC). Seventeen percent were receiving treatment at more than one outpatient venue (e.g., VAMC and Vet Center).

More than three-quarters of the patients were engaged in two or more types of outpatient treatment (individual therapy, group therapy, medication management, mental health intensive case management, psychosocial rehabilitation recovery center programs) during the 3-month time frame. Seventy-two percent received individual therapy, 67 percent received medication management, and 37 percent participated in group therapy.

We reviewed the gender of outpatient MH providers seen prior to admission. Most female patients (83 percent) received outpatient MH treatment from a female therapist or clinician during the 3-month period prior to program participation. Of the 138 patients seen for primary care, 75 percent were seen by a female primary care provider, 8 percent by a male provider, and for 17 percent the gender of the provider was unclear from the EHR.

Referral to Specialized Programs

From EHR review we categorized geographic referral patterns. Although three programs largely served only patients from within the same VISN, most programs drew patients from all areas of the country and these programs appeared to function as a resource for nationwide referral of patients with an MST-related MH conditions.

Program Structure and Treatment Characteristics

Across programs, we found a diversity of structures, program emphases, and treatment approaches through which programs address treatment of female veterans with MST related conditions. Treatments utilized varied by site, but generally included either formalized evidence based therapies (EBPs), mixed therapies comprised of underlying treatment principles from different EBPs, or both, in conjunction with supportive therapies and medication management. Most sites offered cog-

nitive processing therapy as the dominant approach for trauma processing but incorporated other EBPs into the curriculum.

For approximately 60 percent of patients, treatment planning documentation included provision of individual psychotherapy. In programs where individual therapy was provided, we consistently found that the clinician providing the treatment was female. All of the patients participated in one or more types of group therapy. At some sites, clinicians told us that they saw the group milieu as central to the treatment process and therefore emphasized group-based over individual treatment. Both male and female clinicians facilitated groups. We found that groups that focused on discussion of patients' trauma were usually led by female clinicians.

In recent years, VHA has increased emphasis on the use of peer support in the recovery process. We found peer support technician documentation in the EHR (typically as a co-facilitator of a weekly recovery group) at some of the programs we reviewed.

There were differences in the philosophical stance towards same-gender treatment versus mixed-gender treatment. Proponents of women's only treatment programs argue the benefits of the psychological safety inherent in an all-female environment as women veterans explore traumatic experiences. Other clinicians favor mixed-gender treatment. In this model, the presence of men is believed to be normalizing, prepares women to be better able to integrate into the real world environment after program completion, and provides a means to help women confront their fears while in a therapeutic environment. Some program staff we spoke to were in favor of a blended approach. For example, a female veteran may start MST-related PTSD treatment in an all-female environment, but as progress continues, the team may incorporate male staff or add a mixed-gender group to the treatment plan so that the patient can try out new challenges and increase exposure to stimuli that may be typically avoided.

Aftercare

Our EHR review showed that aftercare (follow-up MH services after program discharge) was almost always arranged before women left the program. Generally, aftercare was provided by the referring facility where the veteran had been receiving outpatient MH services prior to admission to the program. This was true whether the referring facility was a medical center, CBOC, Vet Center, or any combination of the above. We usually did not find that treating program staff remained engaged with the veteran after she returned home unless she received her outpatient care at the same facility as the program. Ten women received aftercare from program therapists on an outpatient basis after they relocated to the area where the program was located.

Twenty-two patients were readmitted to an inpatient unit or residential setting within 30 days of program discharge. Three were admitted to medical units, 7 to an acute psychiatry unit within 7 days of discharge and 12 went directly to another MH Residential Rehabilitation Treatment Program at discharge.

Outreach, Access, and Potential Actions to Enhance Program Utilization

Outreach and Utilization - Cohort based admissions involve admitting a group together and keeping the group intact through program completion in order to promote group cohesion. For cohort-based programs, capacity can be estimated by multiplying the number of beds by the number of cohorts offered annually. Program capacity is more difficult to determine with rolling admissions. During site visits and from interviews with program leaders, we found that many of the available beds were not occupied. This corresponds with data from VHA's Northeast Program Evaluation Center that indicates most of these programs do not maintain a full census. A challenge commonly cited by facility staff related to maintaining an adequate volume of women veterans in the programs reviewed. Program staff indicated a need for greater outreach to "get the word out" in order to attract an appropriate and consistent stream of referrals.

Availability of Timely Program Resource Information - The MST Support Team intranet site includes a list of inpatient/residential treatment resources for patients with MST. During our site visits, some program staff noted discrepancies and/or outdated information about their programs on the intranet site. The MST Support Team periodically surveys programs to verify information posted is accurate, but otherwise the team relies on facilities to report changes. Some program staff reported an inordinate amount of time spent reviewing and eliminating referrals inconsistent with program focus. Maintaining a current, accurate, coordinated resource list available with comprehensive program descriptions will serve to facilitate awareness and outreach and increase the flow of appropriate referrals from VA clinicians and coordinators.

Role of MST Coordinators - We met with MST Coordinators during our site visits and frequently heard they had limited time (as little as 2 hours per week in some cases) remaining for outreach activities and/or tracking of patients with positive MST screens, which is a key component of their function as outlined by VHA policy. This occurred because most MST Coordinators' time was dedicated to direct patient care responsibilities.

Aligning VHA MST and Travel Policies - We found that patients were referred to programs in facilities outside of their Veterans Integrated Service Network (VISN) and geographic region. During site visits, difficulties obtaining authorization for patient travel funding was a consistent theme. From EHR review, we noted one veteran whose start date was postponed to the next cohort as the referring facility and treating facility were debating responsibility for transportation costs. One program with a wide national patient distribution indicated that having to pay for roundtrip travel is a challenge, but putting patients first, the program had unilaterally decided to provide funding for bi-directional transportation.

A review of the current policy for MST and the current policy for Beneficiary Travel reveals that the two do not align. The Beneficiary Travel policy indicates that only selected categories of veterans are eligible for travel benefits and payment is only authorized to the closest facility providing a comparable service. Those eligible for travel pay include veterans who: (1) travel for treatment related to a service-connected condition; (2) are service-connected at a rate of 30 percent or more for treatment of any condition; (3) travel for Compensation and Pension examinations; (4) receive a nonservice-connected pension; or (5) are low income as defined by income not in excess of the VA pension rate.

VHA requires that veterans and eligible individuals have access to residential or inpatient programs that are able to provide specialized MST-related mental health care, when clinically needed, for conditions resulting from MST. The MST Directive also states that "at a national level, there is a need to consider developing a number of these programs as national resources and to arrange processes for referral, discharge, and follow-up." The directive requires that "all health care for treatment of mental and physical health conditions related to MST, including medications, is provided free of charge" and that fee basis should be available when indicated.

We recommended that the Under Secretary for Health review existing VHA policy pertaining to authorization of travel for veterans seeking MST-related MH treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled. VHA concurred with our recommendation and established a workgroup to review issues and provide recommendations to the Under Secretary for Health by April 30, 2013. As of VHA's last quarterly update in May 2013 to the OIG on the implementation status of our recommendation, VHA reported the workgroup was continuing its review.

CONCLUSION

The programs reviewed are a valuable resource available to serve clinically complex veterans with a history of MST and associated mental health and psychosocial burden. VHA should establish a centrally coordinated, comprehensive, and descriptive MST program resource list; ensure that MST Coordinators have adequate time to fulfill their outreach role; and review existing travel funding for this population. These efforts may promote fuller utilization by those women veterans who have experienced MST and whose individual clinical course indicates the need for a more intensive level of care than is available on an outpatient basis.

Mr. Chairman, thank you again for this opportunity to testify. I would be pleased to answer questions that you or other Members of the Subcommittee may have.

Prepared Statement of Rajiv Jain, M.D.

Good morning, Chairman Benishek, Ranking Member Brownley, and Members of the Committee. Thank you for the opportunity to discuss the Department of Veterans Affairs (VA) strong commitment to assisting Veterans who experienced sexual trauma while serving on active duty or active duty for training. VA refers to these experiences as military sexual trauma (MST). I am accompanied today by Dr. David Carroll, Acting Chief Consultant for Mental Health Services; and Dr. Stacey Pollack, National Mental Health Director of Program Policy Implementation both from the Veterans Health Administration (VHA).

The statutory definition of MST comes from Title 38 United States Code, Section 1720D and is "psychological trauma, which, in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual

nature, battery of a sexual nature, or sexual harassment while the veteran was serving on active duty or active duty for training.” Sexual harassment is defined as “repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character.”

VA is committed to ensuring eligible Veterans have access to the counseling and care they need to recover from MST. Since the passage of Public Law 102-585 in 1992, which added section 1720D to title 38, United States Code, VA has been developing and executing initiatives to: provide counseling and care to Veterans who experienced MST; monitor MST-related screening and treatment; provide VA staff with training on MST-related issues; and engage in outreach to Veterans about available services.

All VA health care services (inpatient, outpatient, and pharmaceutical services) for physical and mental health conditions related to experiences of MST are provided at no cost to Veterans. Veterans do not need to have a VA disability rating or other documentation that the experience occurred to receive these services. Nor do these Veterans need to be enrolled in VA’s health care system to be eligible to receive MST-related counseling and care under section 1720D. For fiscal year (FY) 2012 the total number of Veterans who received MST-related care was 85,474. This is an increase of approximately 10.7 percent (from 77,198 in FY 2011). These Veterans had a total of 896,947 MST-related treatment encounters in FY 2012, which represents an increase of approximately 13.1 percent (from 792,813 in FY 2011).

My written statement will describe how VA delivers high-quality, state-of-the-art health care to Veterans who have experienced MST, provides education and training for VA staff providing these services, collaborates with the Department of Defense (DoD), and engages in outreach to Veterans who have experienced MST about services VA has available to assist them in their recovery.

I. VA’s Capabilities to Provide MST-related Care

Organizational Structure

VA has an organizational infrastructure that oversees MST-related programming at the national, regional, and facility levels. Every VA medical center has a designated MST Coordinator who serves as a point person for MST issues at the facility and ensures that national and network-level policies related to MST screening, treatment, monitoring, and education and training are implemented. MST Coordinators serve as contact persons for MST-related issues and can help Veterans find and access VA services and programs. Network-level MST Points of Contacts monitor implementation and facilitate communication at a regional level. At a national level, the Veterans Health Administration (VHA) Office of Mental Health Services has program responsibility for MST. The Office of Mental Health Services has a national MST Support Team that monitors MST screening and treatment, oversees MST-related education and training, and promotes best practices in care for Veterans who experienced MST. This MST Support Team also consults with VHA’s Office of Mental Health Services on MST-related policy issues and responds to information requests from VA leadership and other stakeholders.

MST Screening

Recognizing that many survivors of sexual trauma do not disclose their experiences unless asked directly, it is VA policy that all Veterans seen for health care at a VA facility are screened for experiences of MST. Screening is conducted in a private setting by qualified providers who have been trained on how to screen sensitively and respond to disclosures. Veterans who report having experienced MST are offered a referral to local mental health services for further assessment and/or treatment.

The proportion of Veterans screened for experiences of MST across all VHA facilities has increased every year since the national MST Support Team began monitoring it. In FY 2012, approximately 98.7 percent of Veterans seen in VHA outpatient care had a completed MST screen and all VHA facilities met or exceeded the national MST screening target of 90 percent. In FY 2012, 72,497 or approximately 23.6 percent of female Veterans and 55,491 or approximately 1.2 percent of male Veterans seen for health care at a VA facility had reported a history of MST when screened by a VA health care provider.

MST-Related Counseling and Treatment

Every VHA facility provides outpatient MST-related counseling and care to both female and male Veterans. All Veterans seen in VA who screen positive for MST are offered a referral for MST-related treatment. Because MST is an experience, not a diagnosis, not all Veterans who screen positive will need or want treatment. In FY 2012, approximately 72.9 percent of women who screened positive for MST re-

ceived outpatient care for either a mental or physical health condition related to MST; this rate was approximately 58.8 percent among men who screened positive.

Although VA provides free treatment for both physical and mental health conditions related to MST, my testimony focuses in particular on the mental health services that VHA has available for Veterans who experienced MST, as the majority of the care that VHA provides related to MST is for mental health conditions. Specifically, in FY 2012, approximately 56.7 percent of women and 41.5 percent of men who screened positive for MST received outpatient care for a mental health condition related to MST. All VHA health care facilities provide MST-related mental health outpatient services, including psychological assessment and evaluation, psychopharmacological treatment, and individual and group psychotherapy. In addition to general mental health services, specialty mental health services are also available to target problems such as Post-traumatic Stress Disorder (PTSD), substance abuse, and depression. Every facility has providers who are knowledgeable about mental health treatment for the aftereffects of MST. Because MST is associated with a range of mental health problems, VA's general services for PTSD, depression, anxiety, substance abuse, and others are important resources for MST survivors. In addition, many VA facilities have specialized outpatient mental health services focusing specifically on sexual trauma. Many community-based Vet Centers also have specially trained sexual trauma counselors.

For Veterans who need more intensive treatment, many VA facilities have Mental Health Residential Rehabilitation and Treatment Programs (MHR RTP). VA also has inpatient programs available for acute care needs (e.g., psychiatric emergencies and stabilization, medication adjustment).

VA's Uniform Mental Health Services Handbook specifies that evidence-based mental health care must be available to all Veterans diagnosed with mental health conditions related to MST. The Office of Mental Health Services is currently conducting national initiatives to train VA clinicians in a number of evidence-based practices for mental health treatment. Two of the therapies that are being disseminated, Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) are treatments for PTSD. There are also national training initiatives in Acceptance and Commitment Therapy (ACT) and Cognitive Behavioral Therapy (CBT), which are evidence-based psychotherapies for anxiety and depression, two mental health conditions that can result from the experience of sexual trauma. The training initiatives consist of experiential workshop training followed by ongoing clinical case consultation.

Because PTSD, depression, and anxiety are commonly associated with MST, these national initiatives have been an important means of expanding MST survivors' access to cutting-edge treatments. Furthermore, several of these treatments were originally developed in the treatment of sexual assault survivors and have a particularly strong research base with this population. As such, the MST Support Team has worked with each of these national initiatives to ensure inclusion of materials relevant to MST survivors and to promote attendance by clinicians working with MST survivors.

MST Readjustment Counseling Service (Vet Centers)

Veterans who experienced MST may also receive assessment, counseling, and referral services through Vet Centers run by VHA's Readjustment Counseling Service (RCS). RCS is nearing its goal to have a qualified MST counselor on staff at each of its 300 Vet Centers nationwide. To qualify to provide this special mental health service at Vet Centers, the clinician must meet the criteria in the RCS MST Staff Training and Experience Profile (STEP). The MST STEP criteria includes MST-related clinical education and supervision, as well as the professional licensure requirement in a mental health related field. All Vet Center clinical staff are required to complete VA's mandatory training on MST.

In FY 2012, Vet Center staff supported over 5,400 Veterans with over 47,700 visits related to MST. This represents approximately a 25 percent increase in the number of Veterans and a 21 percent increase in the number of visits when compared to the previous fiscal year.

II. MST-related Education for Staff

All VA mental health and primary care providers are required to complete mandatory training on MST. Also, VHA's national MST Support Team hosts monthly continuing education calls on MST-related topics that are open to all VA staff and available online afterwards. Since 2007, the MST Support Team has hosted an annual, multi-day in-person training focused on MST-related program development as well as the provision of clinical care to Veterans who experienced MST. The MST Resource Homepage is a VA intranet community of practice Web site where VA staff

can access MST-related resources and materials, review data on MST screening and treatment, and participate in MST-related discussion forums. In addition, all VA staff have access to an online independent study course on MST and other Web-based training materials.

Since 2008, the MST Support Team has engaged in national activities to support and encourage facilities to host events as part of Sexual Assault Awareness Month (SAAM) in April. These activities include the selection of a national theme, dissemination of support materials, publication of information about SAAM in the VAn-guard magazine and other outlets, and hosting a special national MST training call in April designed to be of general interest to VA staff. At a facility level, MST Coordinators may host medical education conferences and other educational presentations, distribute newsletters or fact sheets, and engage in other activities.

III. Outreach to Veterans

To help ensure information about MST-related services is readily available to Veterans, VA has developed outreach posters, handouts, and educational documents for Veterans, secured inclusion of information about MST on relevant va.gov Web sites, and developed an MST-specific Internet Web site (www.mentalhealth.va.gov/msthome.asp). Also, VA's national MST Support Team has conducted an "Answer the Call" campaign to ensure that Veterans calling VA medical centers with MST-related questions, including about initiating treatment, can reach the facility MST Coordinator. Members of the team conduct test calls to VA medical centers in order to verify that frontline staff such as telephone operators and clinic clerks are familiar with the terms "military sexual trauma" and "MST," are readily able to identify and direct callers to the MST Coordinator, and are sensitive to Veterans' privacy concerns. Facilities receive ratings of Satisfactory, Marginal, or Unsatisfactory based on the results of calls; facilities with less than satisfactory ratings are provided with additional feedback about team members' experiences during the calls and are required to submit action plans to address problems identified.

VA has identified transitioning Servicemembers and newly discharged Veterans as high priority groups for outreach in FY 2013. VA is collaborating with the Department of Defense (DoD) Sexual Assault Prevention and Response Office and other national VA program offices to ensure that these Veterans are aware of MST-related services available through VHA.

At the facility level, MST Coordinators engage in local outreach efforts to raise awareness about the availability of MST-related services. Tip sheets from the MST Support Team help facilitate these efforts. MST is included in "Make the Connection" (www.maketheconnection.net) and "About Face" (www.ptsd.va.gov/aboutface) Web sites featuring Veterans' stories of recovery.

IV. MST Among Special Populations

VA produces annual reports on MST screening and treatment among Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Veterans to help ensure adequate capacity is available to provide MST-related care among this high-priority population. Among OEF/OIF/OND outpatients in FY 2012, 11,107 women (approximately 20.5 percent) and 3,256 men (approximately 0.9 percent) screened positive for MST. Among these Veterans with positive screens, approximately 60.4 percent of women and 53.0 percent of men received outpatient MST-related mental health treatment in FY 2012.

VA also conducts annual special analyses on the rates of MST screening and treatment among homeless Veterans. These analyses revealed that homeless Veterans who use VHA services have higher rates of experiencing MST compared to all Veterans who use VHA. They also receive MST-related mental health care through VA at higher rates, compared to all Veterans who use VA care. Among homeless Veterans using VHA outpatient care in FY 2012, 6,890 (approximately 38.3 percent) women and 6,147 (approximately 3.5 percent) men reported MST. Among these homeless Veterans with positive screens, approximately 87.3 percent of women and 80.4 percent of men received outpatient MST-related mental health treatment.

V. Capacity to Provide MST-Related Care

VA monitors its capacity to provide MST-related mental health care among all Veterans utilizing VA care. The monitoring data shows that all VA facilities provide MST-related care to both female and male Veterans and all facilities have mental health providers knowledgeable in the treatment of MST-related mental health conditions. MST-related mental health outpatient treatment rates for women and men have increased every year since the VA began monitoring them.

The Office of Mental Health Services' national MST Support Team conducted a comprehensive analysis and determined that the minimum number of full-time

equivalent employees (FTEE) required to meet the outpatient MST-related mental health treatment needs of Veterans was 0.2 FTEE per 100 Veterans who screened positive for MST. Comparison to this standard found that approximately 99 percent of VHA facilities were at or above the target level. The MST Support Team has conducted follow-up with the facilities that did not meet the minimum staffing threshold, and those facilities have submitted action plans directed at improving their staffing levels for MST-related mental health treatment.

More generally, the MST Support Team regularly provides technical assistance and consultation to all facilities to ensure the highest capacity and quality of mental health care for Veterans who have experienced MST. This includes developing materials to assist facilities in assessing strengths of their current programming, identifying gaps in services, and implementing best practices.

VI. Identifying Gaps In MST-related Services

The DoD and VA Integrated Mental Health Strategy (IMHS) derives from the 2009 DoD/VA Mental Health Summit and joint efforts in 2009 and 2010 between DoD and VA subject matter experts. The IMHS includes 28 Strategic Actions (SA) focused on establishing continuity between episodes of care, treatment settings, and transitions between the two Departments. IMHS SA #28 was specifically tasked to explore gaps in delivery and effectiveness of prevention and mental health care, for women Veterans and for Veterans (both male and female) who experienced MST. This workgroup is currently engaged in identifying disparities, specific needs, and opportunities for improving treatment and preventive services for women Veterans and Veterans who experienced MST. This workgroup includes VA and DoD clinicians, researchers, and other subject matter experts.

In addition to the work being done through IMHS SA #28, VA is in the midst of focused efforts to address two other gaps in VA's MST-related services. First, 38 U.S.C. Section 1720D, as currently written, only authorizes VA to provide services to Veterans who experienced sexual trauma while on active duty or active duty for training. This does not include members of the National Guard or Reserves who might have experienced sexual trauma while on weekend drill training. As such, these Veterans are not eligible for free MST-related care through VA. Therefore, the FY 2014 budget includes a legislative proposal to expand the population eligible for free MST-related care through VA to those Veterans who experienced sexual trauma while on inactive duty for training.

Finally, VA's Office of Inspector General (OIG) conducted an inspection to review VHA services available to women Veterans who have experienced MST. In examining treatment through inpatient and residential programs, the VA OIG found that women often needed to travel to programs outside their Veterans Integrated Service Network in order to receive appropriate specialized care. However, travel funding often served as a barrier to receiving this care, because Veterans who experienced MST were not necessarily eligible to receive Beneficiary Travel funding through VA. To better align Beneficiary Travel and MST policy, VA has established a workgroup to make recommendations regarding this issue.

Conclusion

Mr. Chairman, our work to effectively treat Veterans who experienced MST continues to be a priority. VA remains focused on providing Veterans timely access to high-quality health care services. We appreciate your support and encouragement in identifying and resolving challenges as we find new ways to care for Veterans. VA is committed to providing the high quality care which our Veterans have earned and deserve. We appreciate the opportunity to appear before you today. My colleagues and I are prepared to respond to any questions you may have.

Prepared Statement of Dr. Karen Guice

Mr. Chairman, Members of the Committee, thank you for the opportunity to discuss the Military Health System's roles and responsibilities in serving the medical needs of survivors of military sexual trauma. Together, with our colleagues at the Department of Veterans Affairs (VA), we provide the necessary health care and related services to ensure that appropriate care is timely, sensitive, and coordinated for these individuals.

The Department of Defense is committed to ensuring our Service members, as well as other survivors of sexual assault for whom we have responsibility, receive comprehensive, high quality, and compassionate medical services where and when they are needed worldwide, and this is what we will focus on today.

We have, just this year, issued a new Department of Defense Instruction (DoDI), 6495.02, that establishes clear guidelines, standards and processes, along with training and reporting requirements, to ensure that a structured, competent and coordinated continuum of health care and related services are available to every sexual assault survivor. This continuum of care begins when a survivor seeks health care services in of our military treatment facilities and extends as they transition to VA care. It is the Department's policy that survivors are treated with dignity and respect, and that those that provide their health care are trained, competent and readily available.

We require that health care is provided in a timely and standardized manner across the Services. Sexual assault survivors who seek care at one of our military medical treatment facilities will be treated as an emergency. This means that they will be seen and examined immediately regardless of evidence of physical injury. Once any emergency treatment has been provided, trained medical staff members talk to the individual about sexual assault forensic exams and offer to perform the exam, or arrange for the individual to get the exam elsewhere. The health care provider also notifies the Sexual Assault Response Coordinator or Victim Advocate and arranges for any necessary and requested health care treatment. This includes appropriate testing and prophylactic treatment options for human immunodeficiency virus (HIV) and other sexually transmitted diseases; access to emergency contraception; referral to mental health services, as well as any follow on care for physical injuries. When feasible, and with the individual's consent, subsequent medical management and care is referred to the patient's own primary care team to facilitate continuity of care and support.

Procedures for conducting sexual assault forensic exams (SAFE) follow the current U.S. Department of Justice Protocol and all medical providers are trained according to this national standard. We require that all military medical treatment facilities stock standardized SAFE kits and that our health care providers use these kits when conducting an exam. Providers are also required to document their examinations using the most current edition of Department of Defense Form 2911 (DD 291), "DoD SEXUAL ASSAULT FORENSIC EXAMINATION REPORT". If the military medical facility does not have appropriately trained providers available to conduct the forensic exam, they must have an agreement with a local civilian facility. All completed forensic exam specimens are properly labeled and provided to the appropriate Military Service law enforcement agency or Military Criminal Investigative Organization, depending on the type of reporting requested by the survivor.

Sexual Assault Response Coordinators or SARCs have the primary responsibility for coordinating care and services for survivors of military sexual assault and are available to respond and speak to these individuals at any time. SARCs are also responsible for counseling the individual on the choice between unrestricted and restricted reports, and for coordinating actions following the individual's reporting decision. When the individual elects to restrict reporting, confidentiality of information is protected through the use of a restricted reporting control number for specimen labeling following a forensic exam. This maintains the chain of custody for evidence should the individual chooses to proceed with unrestricted reporting at a later date.

We have recently reviewed the Services' compliance with policies and guidance issued in the March 28, 2013 DoDI. The Services are in full compliance with the provider availability and training standards. Sexual assault medical forensic examiners are available 24 hours a day, either within the MTF or through current signed agreements with local civilian facilities. Each Service has written policies addressing the specific medical response requirements in accordance with the DoDI.

We recognize that the long-term needs of sexual assault survivors often extend beyond the period in which a Service member remains on active duty. Ensuring that these individuals have a successful and sensitive transition to services and care provided by the VA is essential. For those individuals leaving military service through the Integrated Disability Evaluation System, ongoing health care needs are identified and information is provided about access to health care in the VA. Those military members who leave service outside of IDES receive in depth presentations about VA health care and how to access those services through the Transition Assistance Program.

If the individual is still receiving behavioral health care at the time of separation from the Service, s/he will be linked to the DoD inTransition Program to help ensure that continuity of care is maintained. This program assigns Service members an inTransition support coach to bridge of support between health care systems and providers through coaching assistance services by phone worldwide. The coach does not deliver behavioral health care or perform case management, but is an added resource to health care providers and case managers and supports a seamless transition.

In sum, our DoD health care policies are clear and the Military Departments have been leaning forward and diligent in executing these policies and monitoring compliance. Our approach is structured and aligned with the responsibilities of other stakeholders on military installations and within the community— to include commanders, the personnel community, the legal community, law enforcement, and local civilian authorities.

Mr. Chairman, Members of the Committee, I want to again thank you for the opportunity to appear before you today and discuss this very important issue.

Statements For The Record

THE AMERICAN LEGION

Sexual Assault results in sexual trauma. The Department of Veterans Affairs (VA) reports that approximately one in five women and 1 in 100 men¹ have reported to their healthcare provider they have experienced sexual trauma while in the military. In recent months, military sexual assault cases have dominated national headlines, and sexual assault victims are coming forward in droves. Every sexual assault results in sexual trauma, which is sometimes suffered physically, and nearly always suffered mentally.

VA provides treatment programs for veterans suffering from Post-Traumatic Stress Disorder (PTSD) to address the mental anguish associated with military sexual trauma (MST). The problem is that VA doesn't have a separate program to work with PTSD patients who contracted PTSD as a result of MST. The reason this is a problem is because VA's PTSD therapy is a co-ed treatment program that groups male and female patients together. Trying to address sexual trauma issues in a co-ed setting, in many cases is serving to further exacerbate symptoms and in some cases discouraging patients from remaining in the program. Some female victims have reported to The American Legion that this co-ed residential treatment program is not conducive to their recovery, and that there is not enough separation of men and women participating in the programs to feel confident they will not be victimized again even if sleeping areas are separate.

Nationwide, The American Legion has over 2,600 accredited service officers, which enables us to receive real-time feedback of what is transpiring in the field. One service officer reports that one of his clients, a female veteran receiving treatment for MST-related PTSD, was further traumatized while in the co-ed inpatient facility when one of the male patients reached for a TV remote control that was sitting in her lap. This seemingly benign incident illustrates the intensity of the issues faced by victims of MST, and The American Legion fears that co-ed treatment may only serve to exacerbate these issues in many, if not most cases.

VA has only seven residential treatment programs in the United States fully dedicated to women veterans – specific to the treatment of PTSD. The American Legion believes that the co-ed approach needs to be reconsidered, given the complications associated with this particular issue, and that there should be an expansion of inpatient women veteran treatment programs, in order to address the issues unique to sexual and PTSD trauma victims.

During The American Legion's System Worth Saving site visit at the Coatesville (Pa.) VA Medical Center (VAMC), we were briefed on a program that we believe to be a model for women veterans, called the Power Program. The Power Program is a residential dual diagnosis unit that provides inpatient and residential treatment to eligible female veterans with substance abuse disorders, mental health problems, and homelessness struggles. The program's mission is to prepare female veterans for a lifestyle that supports continued recovery of mind, body and spirit. Patients come from as far away as Denver, Colorado to enroll in the program, and female veterans enrolled in the program stated that they receive excellent care and would recommend the program to other women veterans.

PTSD and sexual trauma are major problems facing women veterans, and we recognize that outpatient programs have received funding and support, and have enjoyed recent expansion. Nevertheless, women veteran inpatient programs are still lacking and women have to leave the local facility or region – and their families – to receive care in a VA site across the country.

The American Legion believes that it is important to remember that this is not an issue that only affects women; far from it. According to surveys of 14 VA medical facilities conducted by The American Legion in the first half of 2013, nearly half

¹ <http://www.va.gov/WOMENVET/2011Summit/Breakout-ResourcesforMSTSsurvivors2011.pdf>

of those being treated for MST were men. According to VA, while it is true that MST proportionally affects more women than men, “because of the disproportionate ratio of men to women in the military there are actually only slightly fewer men seen in VA that have experienced MST than there are women.”² This fact is often overlooked in the discussion of this issue. The American Legion believes that the issues faced by all veterans should be considered and addressed, regardless of gender.

At our 2012 National Convention, The American Legion passed resolution number 295, entitled “Military Sexual Trauma (MST)”, wherein we urged VA to “ensure that all VA medical centers, vet centers, and community-based outpatient clinics employ a MST counselor to oversee the screening and treatment referral process, and to continue universal screening of all veterans for a history of MST”. While we recognize that this does not address the issue of the lack of facilities; victims may still need to travel to a remote facility if they prove to be in need of treatment for MST. We believe that a counselor at each facility will go a long way toward ensuring that this issue gets the recognition it deserves, and that these veterans receive the care they deserve. Furthermore, universal screening both recognizes that this is not an issue which pertains to women only, and helps to reduce the stigma which may be associated with MST.

All this, however, assumes that victims of MST are able to demonstrate service-connection for their MST-related PTSD, such that they are able to receive VA care and/or compensation. In October 2008 the Government Accountability Office released a report entitled “Additional Efforts Needed to Ensure Compliance with Personality Disorder Separation Requirements,” which found that the Department of Defense (DOD) was not doing enough to ensure that service members who were being separated for various personalities were not wrongly denied recognition of a traumatic brain injury (TBI), PTSD and/or MST which may have led to their discharge. Those who have these kinds of injuries as a result of their service may be denied VA healthcare related to these injuries.

At the May 2013 National Executive Committee meetings, The American Legion passed resolution number 26, entitled “Mischaracterization of Discharges for Servicemembers with Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD) and Military Sexual Trauma (MST)”. Outlined in it is a short history of the “less than honorable discharge”, which can be used to deny veterans benefits. Unfortunately, discharges that results from a personality disorder diagnosis denies the veteran any recourse toward receiving the treatment they may be entitled to, if their condition is found to be service connected.

The American Legion is extremely concerned that a great many veterans who experience MST while in the service are being denied care in the VA system. The character of the discharge resulting from the incident in service paradoxically prevents them from accessing care from the VA. The American Legion believes that this must be changed.

In conclusion; in addition to the recommendations set forth in the resolve clauses of the guiding resolutions attached to this testimony, The American Legion recommends more single sex treatment options, and offer care that is gender sensitive and gender specific. We also call on VA to create more gender specific inpatient dormitories that are physically separated by enough physical structure to ensure the reality, as well as the perception of safety for the patients is paramount. And finally, The American Legion calls on this committee to direct VA to carefully review all claims for PTSD that indicate the possibility of sexual assault while on active or reserve duties to ensure that they are not denied the care they need and deserve.

As this issue continues to develop, The American Legion looks forward to working with the Committee, as well as DOD and VA, to find solutions. For additional information regarding this testimony, please contact Mr. Shaun Rieley at The American Legion’s Legislative Division, (202) 861-2700 or srieley@legion.org.

² <http://www.womenshealth.va.gov/WOMENSHEALTH/facts.asp>

**NINETY-FOURTH NATIONAL CONVENTION
OF**

THE AMERICAN LEGION

Indianapolis, Indiana

August 28, 29, 30, 2012

Resolution No. 295: Military Sexual Trauma (MST)

Origin: Convention Committee on Veterans Affairs and Rehabilitation

Submitted by: Convention Committee on Veterans Affairs and Rehabilitation

WHEREAS, Military Sexual Trauma (MST) impacts thousands of brave men and women in the Armed Forces; and

WHEREAS, In FY2010, Department of Defense (DOD) estimated that only 13.5 percent of MST incidents were reported; and

WHEREAS, In addition, reporting of MST is frequently followed by lackluster investigation and prosecution, with many resulting in administrative or dishonorable discharge rather than Uniform Code of Military Justice prosecution; and

WHEREAS, DOD does not have a policy of permanently maintaining files of reported incidents of MST, creating evidentiary roadblocks for future Department of Veterans Affairs (VA) claims; and

WHEREAS, A history of MST has correlations to many health and economic consequences, including PTSD, sexually transmitted infections, homelessness, and substance abuse; and

WHEREAS, According to a 2010 report published by the VA Office of Inspector General, entitled "Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits," Women Veterans Coordinators (WVCs) are frequently underutilized due to lack of public awareness of the services and assistance provided by WVCs; and

WHEREAS, According to the same OIG report, women veterans are disproportionately granted Post Traumatic Stress Disorder (PTSD) claims based on MST; for instance, 9 percent of PTSD claims granted to women veterans by Veterans Benefits Administration (VBA) were on the basis of MST, compared to only 0.1 percent of male veterans; and

WHEREAS, MST claims and treatment involve delicate, sensitive emotional issues; and

WHEREAS, VBA lacks a complete assessment of its system-wide MST-related workload and outcomes, without which it cannot determine if additional MST-specific training and testing is necessary; now, therefore, be it

RESOLVED, By The American Legion in National Convention assembled in Indianapolis, Indiana, August 28, 29, 30, 2012, That The American Legion urge the Department of Defense (DOD) to improve its investigation and prosecution of reported cases of Military Sexual Trauma (MST) to be on par with the civilian system; and, be it further

RESOLVED, That The American Legion urge the DOD to examine the underreporting of MST and to permanently maintain records of reported MST allegations, thereby expanding victims' access to documented evidence which is necessary for future Department of Veterans Affairs (VA) claims; and, be it further

RESOLVED, That The American Legion urge the VA to ensure that all VA medical centers, vet centers, and community-based outpatient clinics employ a MST counselor to oversee the screening and treatment referral process, and to continue universal screening of all veterans for a history of MST; and, be it further

RESOLVED, That The American Legion urge the VA to review military personnel files in all MST claims and apply reduced criteria to MST-related PTSD to match that of combat-related PTSD; and, be it further

RESOLVED, That The American Legion urge the VA to employ additional Women Veterans Coordinators (WVCs) and to provide MST sensitivity training to claims processors and WVCs; and, be it finally

RESOLVED, That The American Legion urge the VA to conduct an analysis of MST claims volume, assess the consistency of how these claims are adjudicated, and determine the need, if any, for additional training and testing on processing of these claims.

NATIONAL EXECUTIVE COMMITTEE

OF

THE AMERICAN LEGION

INDIANAPOLIS, INDIANA

MAY 8 - 9, 2013

Resolution No. 26: Mischaracterization of Discharges for Servicemembers with Traumatic Brain Injury

(TBI) and Post Traumatic Stress Disorder (PTSD) and Military Sexual Trauma (MST)

Origin: Veterans Affairs and Rehabilitation Commission

Submitted by: Veterans Affairs and Rehabilitation Commission

WHEREAS, In 1916, the military began using "blue discharges" which was a form of administrative and less than honorable military discharge whereby servicemembers were subsequently denied the benefits of the G.I. Bill by the Veterans Administration and had difficulty finding work because employers were aware of the negative connotations of their blue discharge; and

WHEREAS, The American Legion lobbied the military and Congress in the original GI Bill legislation that led to the creation of an independent military discharge review board as well as ensured servicemembers with "blue discharges" or other than dishonorable discharges were entitled to their earned veterans benefits; and

WHEREAS, Later during the 1940s to early 1970s, the United States military used Separation Personnel Codes (SPN) or "spin codes" to categorize servicemembers based on discriminatory ailments or behavioral issues that had occurred during their military service; and

WHEREAS, These controversial SPN codes were later overturned through the work of The American Legion and Congress as it unjustly prevented employers from hiring veterans after their military service; and

WHEREAS, Today with the current conflicts in Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF) and Operation New Dawn (OND), the military has again come under intense scrutiny by Congress, veteran service organizations and the media for their discharge policies and reclassification of discharges as either personality disorder, pre-existing and/or adjustment disorders, when these medical conditions did not exist prior to a member's service; and

WHEREAS, In February 2012, Madigan Army Medical Center servicemembers were subjected to a forensic psychiatry team for several years to prevent them from being discharged with a medical retirement due to post traumatic stress disorder (PTSD) or other mental health illnesses incurred in service; and

WHEREAS, Then Senate Veterans Affairs Committee Chairman Patty Murray directed these 1,500 Madigan servicemembers to be reevaluated for their symptoms and 285 of these cases were reversed to ensure they received the proper care and benefits for their injuries and illnesses; and

WHEREAS, In October 2008, the Government Accountability Office (GAO) published a report, "Additional Efforts Needed to Ensure Compliance with Personality Disorder Separation Requirements," as well as a follow up study in September 2010 which found that DOD does not have reasonable assurance that its key personality disorder separation have been followed by the military service branches; and

WHEREAS, It continues to remain unclear what each of the military service branch's directives, policies and protocols are in place for administering personality and adjustment disorders, particularly for servicemembers that are diagnosed with

traumatic brain injury, PTSD, and/or who are victims of military sexual trauma; now, therefore, be it

RESOLVED, By the National Executive Committee of The American Legion in regular meeting assembled in Indianapolis, Indiana, on May 8-9, 2013, That the Veterans Affairs and Rehabilitation Commission and National Security Commission staff conduct a study of existing Department of Defense policies and procedures for character of discharge for servicemembers that served during time of war and were susceptible or diagnosed with traumatic brain injury, post traumatic stress disorder, are victims of military sexual trauma, and/or any other personality related disorders.

DISABLED AMERICAN VETERANS (DAV) on Behalf of The Independent Budget

Messrs. Chairman and Members of the Subcommittee:

Thank you for inviting the DAV (Disabled American Veterans) to testify on behalf of the Independent Budget Veterans Service Organizations (IBVSOs) at this oversight hearing. We appreciate the Subcommittee's focus on the care and treatment available to survivors of military sexual trauma (MST), and the current capabilities of the Department of Veterans Affairs (VA) and Department of Defense (DoD) to provide a structured and coordinated continuum of care to facilitate the recovery of MST survivors, from the time of the incident through transition to veteran status. This testimony is adapted from our discussion of MST in the Fiscal Year 2014 Independent Budget.

For a number of years, the IBVSOs have advocated greater collaboration between VA and DoD to identify best practices for health care services and claims processing for conditions related to MST. We also continue to express a fervent hope that DoD is effectively addressing methods to prevent the incidence of sexual assaults and harassment within all branches of the military services. We note legislation is pending in the Senate that would make changes related to the Uniform Code of Military Justice related to our concern.

This topic is extremely sensitive to service members, veterans and the respective Departments that are responsible for the safety and well-being of service members and veterans. When a service member is wounded by enemy rifle fire or mortar shrapnel in engagement with an enemy, as a society we recognize the sacrifice and loss of our wounded military personnel; but when a military service member is injured from personal or sexual violence, often perpetrated by a fellow service member, military authorities and society in general respond in a very different way.

What is the Department of Defense (DoD) Doing About MST?

In 2005 DoD established the Sexual Assault Prevention and Response Office (SAPRO) to ensure that each military service activity responsible for handling sexual assault complies with DoD policy. SAPRO serves as a single point of oversight of these policies, provides guidance to service branches, and facilitates resolution of common issues that arise in military services and joint commands. The objective of SAPRO is to enhance and improve prevention through training and education programs, ensure treatment and support of victims, and enhance system accountability.

Through SAPRO, DoD has taken a number of steps to improve the situation that confronts service members who have been personally assaulted. These include better reporting, enhanced training and more complete information about the scope of the problem and what needs to be done about it throughout the military command structure.

According to SAPRO, 86.5% of sexual assaults go unreported, meaning that official documentation of many assaults may not exist. Prior to the new records retention laws passed in the 2011 National Defense Authorization Act (NDAA), the services routinely destroyed all evidence and investigation records in sexual assault

cases after two to five years, leaving gaping holes in MST-related claims filed prior to 2012.^{1 2}

The President signed an Executive Order in December 2011 that added Military Rule of Evidence (MRE) 514 into military law which took effect on January 12, 2012. DoD views MRE 514 as a rule structured to protect the communications between a victim and a victim's advocate when a case is handled by a military court. This rule allows victims to trust that what is shared with professionals will remain protected, whereas prior to the advent of MRE 514, DoD victim advocates and sexual assault response coordinators in some cases were compelled to testify about their private communications with survivors.³

Military sexual assault survivors are also informed by military authorities that they now have a new option to request permanent or temporary transfers from their assigned commands or bases, or to different locations within their assigned commands or bases. Procedures for this new expedited transfer option were issued in December 2011. The Services were also directed to make every reasonable effort to minimize disruption to the normal career progression of service members who report that they are victims of sexual assault, and to protect victims from reprisal or threat of reprisal for filing reports.⁴

In April 2012 Secretary of Defense Panetta announced the establishment of independent special victims units to investigate incidents of MST in the military and indicated that DoD would address some of its historic problems in archiving confirming records. Central to the proposed regulations is the elevation of the most serious reports to the attention of a Special Court Martial Convening Authority, a uniformed officer holding at least the rank of Colonel or equivalent. In addition to new training for uniformed personnel and their commanders, the proposed regulations include new centralized records of disciplinary proceedings stemming from these incidents, as well as more therapeutic outlets for survivors.⁵ Also, DoD will require that sexual assault policies be explicitly communicated to all service members within 14 days of their entry onto active duty. DoD has proposed that commanders be required to conduct annual organizational climate assessments to measure whether they are meeting the Department's goal of a culture of professionalism and maintaining zero tolerance for sexual assault within all commands; and that a mandate will be enforced for wider public dissemination of available sexual assault resources, such as DoD's "Safe Helpline," www.safehelpline.org.⁶

What Data Does DoD Possess on Reported Sexual Trauma?

Many service members who experience MST do not disclose it to anyone until many years after the fact, but frequently exhibit lingering physical, emotional or psychological symptoms. When service members experience sexual assault during military service there are a number of unique factors that can prevent or discourage them from coming forward and reporting the incident.⁷

A report required by the FY 2011 NDAA for the period from October 1, 2011 to September 30, 2012 (FY 2012) showed the military branches received a total of

¹ Rachel Kimerling, PhD, Julie Karpenko, MSW; Military Sexual Trauma Support Team, VA Office of Mental Health Services, National Center for PTSD, VA Palo Alto Health Care System; "Mental Health Care for Women Veterans and Treatment for Military Sexual Trauma," PowerPoint May 16, 2012 <http://www.naswvc.com/attachments/article/82/2012%20PTSD%20Dr.%20Kimerling.pdf>

² Testimony of Anu Bhagwati, Executive Director, Service Women's Action Network; U.S. House of Representatives, Committee on Veterans Affairs, Subcommittee on Disability Assistance, "Invisible Wounds: Examining the Disability Compensation Benefits Process for Victims of Military Sexual Trauma," July 18, 2012 <http://veterans.house.gov/witness-testimony/ms-anu-bhagwati-0>

³ Witness Testimony of Col. Alan Metzler, Deputy Director, Sexual Assault Prevention and Response Office, U.S. Department of Defense; United States House of Representatives, Committee on Veterans Affairs, "Invisible Wounds: Examining the Disability Compensation Benefits Process for Victims of Military Sexual Trauma," July 18, 2012 <http://veterans.house.gov/witness-testimony/col-alan-metzler>

⁴ *Ibid.*

⁵ ABC News, "Panetta Introduces Initiatives to Fight Sexual Assault in the Military," April 16, 2012 <http://abcnews.go.com/blogs/politics/2012/04/panetta-introduces-initiatives-to-fight-sexual-assault-in-the-military/>

⁶ Lisa Daniel, American Forces Press Service, "Panetta, Dempsey Announce Initiatives to Stop Sexual Assault," April 16, 2012 <http://www.defense.gov/news/newsarticle.aspx?id=67954>

⁷ Garry Trudeau and Loree Sutton, The Washington Post, "Breaking the Cycle of Sexual Assault in the Military," June 29, 2012 <http://www.washingtonpost.com/opinions/breaking-the-cycle-of-sexual-assault-in-the-military/2012/06/29/gJQAK0wNCW-story.html>

3,374 reports of sexual assault. Of these, 2,558 were unrestricted reports and 816 were restricted reports. This data represents a six percent increase since FY 2011.⁸

Of the 1,713 alleged offenders under the legal authority of the Department, commanders had sufficient evidence to take disciplinary action against 66 percent of them, an increase from 57 percent in FY 2009. Of those whose court-martials were concluded in FY 2012, 79 percent were convicted of at least once charge, 19 percent had charges dismissed, and 25 percent were granted a discharge or resignation in lieu of court-martial.⁹

What Data Does VA Possess on Veterans Who Report MST?

In its health care system, VA screens all enrolled patients for MST. National screening data show that about one in five women and one in 100 men respond that they had experienced MST.

According to VA for FY 2012, 23.6% of women (72,497) and 1.2 percent of men (55,491) treated in VA facilities screened positive for MST. 72.9% of women who screened positive for MST received outpatient MST-related care of any kind; 56.7% received MST-related outpatient mental health care. 58.8% of men who screened positive for MST received outpatient MST-related care of any kind; 41.5% received MST-related outpatient mental health treatment.

Of OEF/OIF/OND veteran VHA users, 20.5% of women and 0.9% of men screened positive. Among veterans with positive MST screens, 60.4% of women and 53.0% of men received outpatient MST-related mental health treatment in FY 2012. According to VA this population utilizes MST-related mental health care at higher rates than other Veterans, suggesting targeted outreach efforts to this population have resulted in higher utilization of VHA services.

These rates are almost certainly an underestimate of the actual rate of MST, given that in general sexual trauma is frequently underreported. Also, these data address only the rate of MST among veterans who have chosen to enroll in VA health care; they do not address the actual rate for the veteran population in general. Although veterans who respond “yes” when screened are asked if they are interested in learning about MST-related services available, not every veteran necessarily consents to treatment.¹⁰

Rates of veterans utilizing MST-related mental health outpatient care have been increasing over time; and recently discharged veterans utilized MST-related mental health services at higher rates than other veterans.^{11 12}

% of veterans with a positive MST screen who have at least one MST-related Mental Health encounter

	Women	Men
All veterans	55.3%	39.6%
OEF/OIF/OND veterans	58.9%	51.0%

Homeless veterans who use VHA services also report higher rates of MST compared to all veterans and they receive MST-related mental health care at higher rates compared to all veterans who use VA care.¹³

⁸ Fact Sheet on DoD Sexual Assault Prevention & Response Strategic Plan & Annual Report on Sexual Assault in the Military for FY 2012, May 7, 2013

⁹ *Ibid.*

¹⁰ Department of Veterans Affairs, National Center for PTSD, Military Sexual Trauma Fact Sheet, August 2012 <http://www.mentalhealth.va.gov/docs/mst-general-factsheet.pdf>

¹¹ Rachel Kimerling, PhD, Julie Karpenko, MSW; Military Sexual Trauma Support Team, VA Office of Mental Health Services, National Center for PTSD, VA Palo Alto Health Care System; “Mental Health Care for Women Veterans and Treatment for Military Sexual Trauma,” PowerPoint May 16, 2012 <http://www.naswvc.com/attachments/article/82/2012%20PTSD%20Dr.%20Kimerling.pdf>

¹² Amy Street, PhD; , VA Office of Mental Health Services, National Center for PTSD; “VHA Response to Military Sexual Trauma,” PowerPoint Presentation, April 10, 2012.

¹³ Rachel Kimerling, PhD, Julie Karpenko, MSW; Military Sexual Trauma Support Team, VA Office of Mental Health Services, National Center for PTSD, VA Palo Alto Health Care System; “Mental Health Care for Women Veterans and Treatment for Military Sexual Trauma,” PowerPoint May 16, 2012 <http://www.naswvc.com/attachments/article/82/2012%20PTSD%20Dr.%20Kimerling.pdf>

	Women	Men
% of homeless veteran VHA users with a positive screen for MST	39.3%	3.3%
% of homeless veterans with a positive screen for MST who have at least one MST-related MH encounter	88.9%	79.4%

What is VHA doing to Help Veteran Survivors of MST?

Every VA health care facility employs an MST coordinator to answer questions veterans might raise about MST services. A variety of resources have been developed and distributed for the use of MST coordinators, including tip sheets, posters, handouts, and contact cards. Emphasis has been placed on the importance of ensuring this information is available at key entry and access points (e.g., telephone operators, information desks, clinic clerks, facility websites). Each facility also has care providers who are knowledgeable about treating MST patients. Many VA facilities have developed specialized outpatient mental health services focusing specifically on sexual trauma, and VA's 300 Vet Centers also offer sexual trauma counseling. VA has almost two dozen programs nationwide that offer specialized MST treatment in residential or inpatient settings for veterans who need more intense treatment and support. Because some veterans are not comfortable in mixed-gender treatment settings, some facilities maintain separate programs for men and women; and all residential and inpatient MST programs require separate sleeping areas for men and women.¹⁴ ¹⁵

What are the Challenges in VA for Veterans Who Experience MST?

According to VA, victims of MST present a wide variety of treatment needs.¹⁶ Although posttraumatic stress disorder (PTSD) is commonly associated with MST, it is not the sole diagnosis resulting from MST. Across a range of studies, VA research indicates that men and women who report sexual assaults or harassment during military service were more likely to be diagnosed with mental health challenges. Women with MST had a 59 percent higher risk for mental health problems; the risk among men was slightly lower, at 40 percent.¹⁷ The most common conditions linked to MST were depression, PTSD, anxiety, adjustment disorder, and substance-use disorder.¹⁸

In December of 2012, the Office of the VA Inspector General issued a health care inspection report, *Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma*. The IG concluded that women veterans were often admitted to specialized programs outside their Veterans Integrated Service Network (VISN) and that obtaining authorization for reimbursement of travel expenses was frequently cited as a problem for both patients and staff. The Beneficiary Travel policy indicates that only selected categories of veterans are eligible for travel benefits, and payment is authorized only from the veteran's home to the nearest facility providing a comparable service. The IG noted the current directive is not aligned with the MST policy. The directive states that patients with MST should be referred to programs that are clinically indicated regardless of geographic location. Some programs cited challenges maintaining an adequate volume of appropriate referrals; others reported to the IG that managing women with eating disorders was a particular challenge. Additionally, many MST Coordinators they interviewed reported that they had insufficient time to adequately meet their women's outreach responsibilities.

¹⁴ <http://www.mentalhealth.va.gov/msthme.asp>

¹⁵ Rachel Kimerling, PhD, Julie Karpenko, MSW; Military Sexual Trauma Support Team, VA Office of Mental Health Services, National Center for PTSD, VA Palo Alto Health Care System; "Mental Health Care for Women Veterans and Treatment for Military Sexual Trauma," PowerPoint May 16, 2012 <http://www.naswvc.com/attachments/article/82/2012%20PTSD%20Dr.%20Kimerling.pdf>

¹⁶ Department of Veterans Affairs, National Center for PTSD, Military Sexual Trauma Fact Sheet, August 2012 <http://www.mentalhealth.va.gov/docs/mst-general-factsheet.pdf>

¹⁷ Department of Veterans Affairs, VA Research Currents, November-December 2008. <http://www.research.va.gov/resources/pubs/docs/va-research-currents-nov-dec-08.pdf>

¹⁸ Department of Veterans Affairs, National Center for PTSD, Military Sexual Trauma Fact Sheet, August 2012 <http://www.mentalhealth.va.gov/docs/mst-general-factsheet.pdf>

We concur with the IG's recommendations that the Under Secretary for Health review existing VHA policy pertaining to authorization of travel for veterans seeking MST related mental health treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled.

Although this Subcommittee is primarily focused on the coordinated continuum of health care for MST survivors between DoD and VA, we offer our comments on the Veterans Benefits Administration's (VBA) claims process for MST-related conditions since there are several gaps that exist between the Departments that are of concern to the IBVSOs and veterans. Many veterans indicate their frustration with the claims process, particularly in cases when the sexual assaults were not officially reported. They express feeling "re-traumatized" in their efforts to gain help from VBA even when they have provided significant evidence; statements from witnesses, friends or family; detailed accounts of the incidents; along with VA and non-VA diagnostic and treatment records—only to see their claims denied.

Compensation and pension examinations can also be traumatic for veterans who have been personally assaulted because examiners often require them to recount in detail these devastating experiences, and to do so with someone uninvolved in their VA care or therapy. These experiences often take years for veterans to overcome. Veteran survivors of MST repeatedly tell us they should not be forced to repeat their experiences about the trauma to strangers who often lack the sensitivity or professional qualifications to counsel survivors of sexual trauma. The trust that is built between an MST counselor or mental health provider and a patient is one that should not be trivialized or ignored. Because of the special nature of these particular conditions, VBA should employ the clinical and counseling expertise of sexual trauma experts within VHA or other specialized providers during the compensation examination phase.¹⁹

In response to hearing continued complaints about disparities in MST-related PTSD claims, VA acknowledged that due to the personal and sensitive nature of the MST stressors in these cases, victims often fail to report or document the trauma of sexual assault. If the MST event subsequently leads to post-service PTSD symptoms and a veteran files a claim for disability, the available evidence is often insufficient to establish the occurrence of a stressor event. To remedy this, VA developed regulations and procedures that allow more liberal evidentiary documentation requirements and more sensitive adjudication procedures for these particular claims.²⁰

In its new procedures and similar to adjudicating other PTSD claims, VBA initially reviews the veteran's official military personnel records (including military health records) for evidence of MST. According to VBA, such evidence may include: 1) DD Form 2910, Victim Reporting Preference Statement; and 2) DD Form 2911, Sexual Assault Forensic Examination Report). Unfortunately, based on several years of work in this field, the IBVSOs have ascertained that DD Forms 2910 and 2911 are not made part of service members' official military personnel records, but are retained in confidential files that have generally been unobtainable, even by a survivor who filed them.

The VBA regulation also provides that evidence from sources other than service records may support a veteran's account of an incident, such as evidence from law enforcement authorities; rape crisis centers; mental health counseling centers; hospitals; physicians; pregnancy tests; tests for sexually transmitted diseases; and statements from family members, roommates, fellow service members, etc.²¹

Documented behavioral changes are another type of relevant evidence that may establish that an assault occurred, such as requests for reassignment; deterioration in work performance; substance abuse; depression, panic attacks, or anxiety without an identifiable cause; and unexplained economic or social behavioral changes. Veterans are requested to submit or identify any such evidence they may possess. When this type of evidence is obtained, VA is required to schedule the veteran for an examination with a mental health professional and requests an opinion as to whether the claimed in-service MST stressor occurred. This opinion can serve to es-

¹⁹Testimony of Anu Bhagwati, Executive Director, Service Women's Action Network; U.S. House of Representatives, Committee on Veterans Affairs, Subcommittee on Disability Assistance, "Invisible Wounds: Examining the Disability Compensation Benefits Process for Victims of Military Sexual Trauma," July 18, 2012 <http://veterans.house.gov/witness-testimony/ms-anu-bhagwati-0>

²⁰Testimony of Thomas Murphy, Department of Veterans Affairs, Director of C&P Service, U.S. House of Representatives, Committee on Veterans Affairs, Subcommittee on Disability Assistance, "Invisible Wounds: Examining the Disability Compensation Benefits Process for Victims of Military Sexual Trauma," July 18, 2012 <http://veterans.house.gov/witness-testimony/mr-thomas-murphy-2>

²¹*Ibid.*

establish occurrence of the stressor, one element necessary for establishing service connection.²²

VBA reports it is taking steps to assist veterans with resolution of these claims and has placed a primary emphasis on informing VA regional office personnel of the issues unique to MST, and is providing training in improved claims development and adjudication. During August 2011, VBA reviewed a statistically valid sample of approximately 400 MST-PTSD claims with the goal of assessing current processing procedures and formulating methods for improvement. This led to development of an enhanced training curriculum with emphasis on standardizing evidentiary development practices, as well as issuance of a new training letter and other information to all VA regional offices.²³ The training focused on how to identify circumstantial evidence (called “markers”) indicating that the claimed MST stressor may have in fact occurred. As a result of these and other actions, VBA is reporting the post-training grant rate has risen from about 38 percent to over 50 percent. This change compares favorably with the overall PTSD grant rate of 55–60 percent, according to VBA. Additionally, in December 2012, VBA’s national quality assurance office completed a second review of approximately 300 PTSD claims based on MST that were denied following medical examination. The review showed an overall accuracy rate of 86 percent, which is roughly the same as the current national benefit entitlement accuracy level for all rating-related end products.²⁴

In addition to these general training efforts, VBA provided its designated Women Veterans Coordinators with updated specialized training. These employees are located in every VA regional office and are available to assist both female and male veterans with their claims resulting from MST. They also serve as a liaison with the women veterans’ program managers at local VA health care facilities to coordinate any required health care. As a further means to promote adjudication of these claims consistent with VA’s regulation, VBA has recently created dedicated specialized MST claims processing teams within each VA regional office for exclusive handling of MST-related PTSD claims. Additionally, because the medical examination process is often an integral part of determining the outcome of these claims, VBA has worked closely with the VHA Office of Disability and Medical Assessment to ensure that specific training was developed for clinicians conducting PTSD compensation examinations for MST-related claims.²⁵

However, because earlier denied claims did not get the benefit of these new nationwide training resources, the Under Secretary for Benefits determined that VBA would contact those veterans who had received denials and offer them an opportunity to have their claims re-adjudicated. The IBVSOs have been informed that VBA has sent an outreach letter to 2,556 veterans who had been denied service-connection for MST-related conditions.

Unfortunately, VSOs were not notified prior to the letter being sent out to these veterans. The IBVSOs asked VBA officials to inform us of the names of the veterans for whom we hold Power of Attorney (POA), and thus represent, so that we can properly assist them if they wish VBA to re-adjudicate their claims. VSOs are a critical partner in the claims process and ensuring that the veteran fully understands what evidence is necessary or can support their claim, and to ensure these claims are properly re-evaluated by VBA. We also note that the letter that went out contained no information about how VBA has tried to improve the processes, sensitivity and understanding of MST related claims and minimal information about why VBA was inviting re-evaluation of these claims. Finally, the IBVSOs pointed out the letter directs the veteran to contact his or her local regional office to request review of their previously denied claim, but did not provide any contact information. While we are pleased with the Under Secretary for Benefits’ efforts to improve claims processing for these complex claims we urge continued Congressional oversight to ensure VBA in fact has a consistent and comprehensive approach, throughout the system, to properly address these claims and more importantly set up a case management system to work with individual veteran survivors of MST in a more sensitive

²² *Ibid.*

²³ *Ibid.*

²⁴ Testimony of Curtis L. Coy, Deputy Under Secretary for Economic Opportunity, Veterans Benefits Administration, Department of Veterans Affairs, United States Senate Committee on Veterans’ Affairs, “Pending Benefits Legislation Hearing,” June 12, 2013 <http://www.veterans.senate.gov/hearings.cfm?action=release.display&release=id=6d839502-3b01-4a1f-9dd2-6292724455a0>

²⁵ Testimony of Thomas Murphy, Department of Veterans Affairs, Director of C&P Service, U.S. House of Representatives, Committee on Veterans Affairs, Subcommittee on Disability Assistance, “Invisible Wounds: Examining the Disability Compensation Benefits Process for Victims of Military Sexual Trauma,” July 18, 2012 <http://veterans.house.gov/witness-testimony/mr-thomas-murphy-2>

manner so they that they are not re-traumatized during the claims process. For veterans without a VSO/ POA, having a designated person or point-of-contact in VBA would make it much easier and more comfortable for the veteran to have questions answered about correspondence from VBA regarding their claim.

What Are the Challenges Ahead?

Under DoD's confidentiality policy, military victims of sexual assault can file a restricted report and confidentially disclose the details of the assault to specified individuals and receive medical treatment and counseling, without triggering any official criminal or civil investigative process. Despite the progress on the VA's part to include SAPRO information in its M21-1 manual, to maintain confidentiality in the case of restricted reporting, DoD policy prevents release of MST-related records with limited exceptions. However, VA is not specifically identified as an "exception" for release of records in DoD's policy, and it is unclear if VA could gain access to these records even with permission of a veteran survivor. One of the IBVSOs' primary concerns is that VA be able to access restricted DoD records (with the veteran's permission) documenting reports of MST for an indeterminate period. To establish service connection for PTSD there must be credible evidence to support a veteran's assertion that the stressful event actually occurred. Restricted records are highly credible resources but it is questionable if they are readily available, even with the consent of the veteran. With the veteran's authorization, the IBVSOs believe DoD should provide VA adjudicators access to all MST records, whether restricted or unrestricted, to aid VBA in adjudicating these cases.

The IBVSOs strongly believe that survivors of sexual assault during military service deserve recognition and assistance in developing their claims and compensation for any residual conditions found related to the assault. These cases need and deserve special attention and due to the circumstances of these injuries, and survivors who have courageously come forward need to be consistently and fairly recognized by the government.

The IBVSOs are pleased with the progress VA has made with the increased attention on MST-related information that encourages veterans to have more informed conversations with VA staff about the many available services, benefits, and treatment options. On the other hand, while DoD is moving more forcefully to stem sexual assault events in the ranks, DoD and VA need to resolve their differences with regard to MST-related records availability, both to VA health care professionals and to VBA adjudicators.

Summary

The Subcommittee expressed interest in learning about the coordinated efforts between DoD and VA regarding a continuum of care to facilitate recovery of MST survivors from the point-of-incident through veteran status. The IBVSOs have no knowledge that a structured or defined program exists between the two Departments in this regard. SAPRO governs how each of the military services under DoD handles sexual trauma reporting options and access to treatment, but each of the military branches is responsible for developing its own sexual assault and response prevention campaign to address this pressing issue. The IBVSOs are unaware of any specific protocol for interagency hand-off of MST survivors, but we note that DoD included in the revised April 2013 Sexual Assault Prevention and Response Strategic Plan the goal of collaborating with VA and the veterans service organization community to develop a victim continuity of care protocol for service members who are being discharged from military service due to sexual assault. The IBVSOs are supportive and urge the implementation of this plan, and we look forward to working with DoD to accomplish it. We also recommend that DoD, VA, or both agencies inform a service member following the report of a sexual assault, or prior to discharge, about the benefits and health care services that are available in VA, and to offer assistance in connecting with an MST coordinator at a local VA medical facility or Vet Center.

For the Subcommittee's purposes, the IBVSOs have developed a number of recommendations for Congress, VBA and VHA in improving health care and benefits procedures related to MST treatment and benefits claims. To conclude our testimony, we offer those recommendations for the Subcommittee's consideration:

- We urge VBA to identify and map all claims by gender related to personal trauma with a focus on MST to determine the number of claims submitted annually, their award rates, denial rates, and the conditions most frequently associated with these claims, and to make this information available to the public.
- VBA must properly train its claims staff to be compliant with the VBA procedures and policies intended to assist veterans in producing fully developed

claims; and VBA should conduct continued oversight to review these claims to ensure the directives that have been issued are in fact being followed.

- Given the complexity of MST-related claims, VBA should revise the current work credit system for rating specialists, which seems to reward speed over accuracy in claims determinations, to ensure these particular claims related to MST are adequately researched and properly resolved.
- VBA should establish a designated person or point-of-contact in VBA for veterans to have questions answered about correspondence from VBA regarding their MST-related claims.
- VA should establish a presumption of soundness of MST-related diagnoses made by VA's own physicians and counselors who are caring for MST survivors in VA facilities; VBA claims reviewers should not be enabled to second-guess evaluations by these VA medical and counseling professionals, or to discount established and official VA treatment records, in favor of single point-in-time compensation and pension evaluations made by contract examiners who may be unfamiliar with the nuances associated with MST.
- The Under Secretary for Health review existing VHA policy pertaining to authorization of travel for veterans seeking MST related mental health treatment at specialized inpatient/residential programs outside of the facilities where they are enrolled.
- DoD and VA need to resolve their differences with regard to MST-related records availability, both to VA health care professionals and to VBA adjudicators.
- Congress should continue its oversight and hearings to stimulate VA and DoD to improve their policies and practices for MST care and claims compensation.
- Given the dual nature of this problem as pointed out in our testimony, and the obstacles that affect both health care and benefits of MST survivors, the IBVSOs urge this Subcommittee to coordinate closely with the Subcommittee on Disability Assistance and Memorial Affairs, as well as the Committee on Armed Services, in a combined effort to find ways to further improve VA's coordination with DoD on these difficult and challenging cases.

Mr. Chairman and Members of the Subcommittee, this concludes my testimony on behalf of the Independent Budget veterans service organizations.

Questions For The Record

Letter From: Hon. Julia Brownley, Ranking Member, Subcommittee on Health, To: Hon. Eric K. Shinseki, Secretary, U.S. Department of Veterans Affairs

July 24, 2013

The Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our Subcommittee on Health hearing entitled, "Safety for Survivors: Care and Treatment for Military Sexual Trauma" that took place on July 19, 2013, I would appreciate it if you could answer the enclosed hearing questions by the close of business on August 26, 2013.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Jian Zapata at jian.zapata@mail.house.gov. If you have any questions, please call (202) 225-9756.

Sincerely,

Julia Brownley
Ranking Member

Subcommittee on Health

JB:cw

Questions from Rep. Dina Titus

Questions for Rajiv Jain M.D., Assistant Deputy Undersecretary for Patient Care Services, Office of Patient Care Services, VHA, VA

1. As Ranking Member of the Disability Assistance Subcommittee, I am working every day to improve VBA. On this issue, VBA plays a role along with VHA to provide the support veterans need.

- a. What is the extent of the coordination between VHA and VBA on issues of military sexual trauma?
- b. What can be done to improve this coordination?
- c. What information is provided to veterans who are victims of MST to ensure they are aware of benefits that may be available through VBA?

Letter From: Hon. Julia Brownley, Ranking Member, Subcommittee on Health, To: Hon. George J. Opfer, Inspector General, Department of Veterans Affairs

July 24, 2013

The Honorable George J. Opfer
Inspector General
Department of Veterans Affairs
Office of Inspector General (50)
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Opfer:

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Due to the delay in receiving mail, please provide your response to Jian Zapata at jian.zapata@mail.house.gov. If you have any questions, please call (202) 225-9756.

Sincerely,

Julia Brownley
Ranking Member
Subcommittee on Health

JB:cw

Questions from Rep. Dina Titus

Questions for Michael Shepherd M.D., Office of the Inspector General, VA

1. What types of investigations do you perform at individual VA health facilities to ensure that MST services are being provided in the most effective and time efficient way possible? For example, what will you do to examine the newly opened VA hospital in Southern Nevada?

2. One of your recommendations to VHA was to establish a centrally coordinated, comprehensive, and descriptive MST program resource list. What has been the re-

sponse from the VA? Please elaborate as to how you see such a clearinghouse being structure.

3. VA policy requires that veterans who have MST-related PTSD be informed that they may use information from sources other than their service records to establish credible evidence of the stressors from MST they have endured before VA can deny their claim.

- a. In your observation and experience with MST cases, is this being done?
- b. How is this policy playing out when veterans attempt to bring this evidence to bear?